LOUISIANA
FY 09-10

Community Mental Health Services Block Grant Application

FY 2010 Plan

September 1, 2009
Approved October 30, 2009

Office of Mental Health
Department of Health and Hospitals

LOUISIANA
FY 2010

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION

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LOUISIANA FY 2010
BLOCK GRANT PLAN

Part A

Context & Overview of FY 2010 Application

PART A: FACE SHEET

FISCAL YEARS COVERED BY THE PLAN (Please check as appropriate)

√ FY 2010

STATE NAME: **Louisiana**

DUNS#: **809927064**

I. AGENCY TO RECEIVE GRANT
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, (P.O. Box 4049)**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066**

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: **Jennifer Kopke** TITLE: **Assistant Secretary**
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, (P.O. Box 4049)**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066**

III. STATE FISCAL YEAR
FROM: **July 1, 2009** TO: **June 30, 2010**

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
NAME: **Cathy Orman Castille, PhD, MP**
TITLE: **Block Grant Planner,**
Division of Planning, Data Management, & Compliance
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, P.O. Box 4049**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066** EMAIL: Cathy.Castille@LA.GOV

EXECUTIVE SUMMARY
LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

The Louisiana Office of Mental Health (OMH) Block Grant Plan for FY 09-10 provides direction and implementation strategies for further development of the state's comprehensive, community-based mental health system. The core belief inherent in this Plan is that *treatment works:* people with mental illness recover and become productive citizens. The underlying values of the service system include the expectation that the system be *consumer and child centered*. The mental health program in Louisiana focuses on *education, prevention and recovery while teaching and enhancing resilience.* The locus of services, management, and decision making continues to rest at the *community level*. It is the aim of the service system to follow the direction provided by the *President's New Freedom Commission Report* and to offer individualized, evidence-based, culturally competent services in a seamless manner that assures adequate and equitable service access. Quality, efficiency, data-based decision making, and demonstrated positive client outcomes are basic expectations within the system.

In early 2008, Louisiana began a new administration at all levels (Governor, Department of Health and Hospitals, and the Office of Mental Health) and as a result, many changes continue in the governance of the State. With a strong background in healthcare at both the state and federal levels, Governor Bobby Jindal has promised that improving the health of Louisiana citizens will be a priority in his administration. The Assistant Secretary (i.e., Commissioner) of the Office of Mental Health, Jennifer Kopke, previously was the Executive Director of the Jefferson Parish Human Services Authority (JPHSA). JPHSA is the longest operating local governing healthcare entity in the state, and with her experience, qualifies Ms. Kopke to lead the state in transforming the mental health care system.

Due to Hurricanes Katrina and Rita in 2005 and Gustav and Ike in 2008, there is no argument that the recent past has been a trying time for the citizens of the state in many, many ways. Discussion of the direction of Louisiana after August, 2005 cannot be undertaken without reflection on the effects of the hurricanes. Throughout the Block Grant application, references are made to the effects of these devastating storms. Interruption of consumer activities and clinical services has been unavoidable with each storm. While the Southern part of the state sustains the most direct damage from hurricanes, the rest of the State also experiences repercussions from these storms. Following the 2005 storms, the sense of community changed for all citizens, including Louisiana's children and elderly. For evacuees, their lives were uprooted, and even today, many have no homes, schools, or neighborhoods to return to. Those who have returned find their communities permanently changed, and they are working to rebuild their lives. Other regions of the state have taken in evacuees; forever changing their schools, communities, and lives. For individuals with mental illness, the loss of community is perhaps the most profound loss of all. While the state can be said to be recovering from and coping with, the initial losses of clinic and hospital infrastructure, the out-migration of the healthcare workforce continues to be a major problem and this loss severely interferes with the ability of OMH to serve consumers.

The national economy and multiple budget reductions have also begun to impact the citizens of the state. However, adversity also presents the *opportunity* for re-examination and transformation. It is with this optimism, hope, and enthusiasm that the FY 2010 Plan is presented.

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part B

Administrative Requirements, Fiscal Planning Assumptions, & Special Guidance

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part B
Section I

Federal Funding Agreements, Certifications and Assurances

BOBBY JINDAL
Governor

State of Louisiana
Office of the Governor

July 13, 2009

Ms. Barbara Orlando
Grants Management Office
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

This letter is to serve as formal authorization for Ms. Jennifer Kopke, Assistant Secretary of the Office of Mental Health, to have the power of signature for the Community Mental Health Block Grant Application, as well as recognition of Ms. Kopke as the appropriate authority to receive the Louisiana Community Mental Health Block Grant funds.

If you have any questions, or need additional information, please call Ms. Kopke at 225-342-2540.

Thank you.

Sincerely,

Bobby Jindal
Governor

Post Office Box 94004, Baton Rouge, Louisiana 70804-9004 • (225) 342-7015 • Fax (225) 342-7099
www.gov.state.la.us

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2010

I hereby certify that _____Louisiana _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Jennifer Kopke *August 17, 2009*

~~Governor or~~ Governor Designee Date

Jennifer Kopke
Assistant Secretary
Office of Mental Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Jennifer Kopke	Assistant Secretary
APPLICANT ORGANIZATION	DATE SUBMITTED
LA Department of Health & Hospitals, Office of Mental Health	*August 17, 2009*

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

Approval Expires: 08/31/2007

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.);
(g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	Title:
Jennifer Kopke	Assistant Secretary
Applicant Organization Submitted:	Date Submitted:
LA Department of Health & Hospitals, Office of Mental Health	*August 17, 2009*

PUBLIC COMMENTS ON THE CONTENT OF THIS PLAN ARE WELCOMED AND MAY BE SUBMITTED TO :

LOUISIANA OFFICE OF MENTAL HEALTH

Dr. Cathy Orman Castille, Block Grant State Planner
Office of Mental Health
Department of Health & Hospitals
628 N. 4th Street, 4th Floor
P.O. Box 4049
Baton Rouge, LA 70821-4049
225-342-2540
Cathy.Castille@LA.GOV

PLANNING COUNCIL LIAISON

Melanie Roberts, M.S.
Office of Mental Health
Department of Health & Hospitals
628 N. 4th Street, 4th Floor
P.O. Box 4049
Baton Rouge, LA 70821-4049
225-342-8552
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LOUISIANA MENTAL HEALTH PLANNING COUNCIL

Ms. Jennifer Jantz, Chair
Louisiana Mental Health Planning Council
POB 40517
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Public Comments on the Block Grant Plan are encouraged through a variety of means. The public is invited to submit comments to the Office of Mental Health after reviewing the document.

The Planning Council, consisting of 40 members representing all geographic areas of the State, is instrumental in developing priorities and directions for the Block Grant Plan each year. Input is

solicited from consumers, family members, providers, and state employees who are all members of the Planning Council.

Each year, the Block Grant Plan is available for review via the Office of Mental Health website. Email notices are sent to the Regional Managers, LGE Executive Directors, and Planning Council members when the Block Grant Plan is initially placed on the website. The current draft of the Block Grant is placed on the OMH website publication link, with instructions for submitting comments.

In addition, during the Spring of 2008, a yahoo groups listserv was activated for the Planning Council. The listserv continues to provide a means for posting attachments and documents for the Planning Council; including drafts of the Block Grant application.

Plans are now submitted via the SAMHSA Web-based Block Grant Application System (BGAS), which provides another means of public access to the plan.

Bound hard copies of the plan are available at no charge to the public, and can be either picked up at the OMH State Office or mailed out by request. It is emphasized that public comment is encouraged, and feedback and suggestions for improvements are welcomed. The mechanism to enable this process is included, with contact information for the State Block Grant State Planner, the Planning Council Liaison, and the Planning Council.

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part B
Section II & III

CHILDREN'S SET-ASIDE
AND
MAINTENANCE OF EFFORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Set-Aside for Children's Mental Health Services

Data Reported by: State FY July 1, 2008 – June 30, 2009

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2008	Estimated/ Actual FY 2009
$1,202,120	$16,043,045	$15,825,056

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion. States are required to submit State expenditures in the following format:

MOE Information Reported by: State FY July 1, 2008 – June 30, 2009

State Expenditures for Mental Health Services

Actual FY 2007	Actual FY 2008	Actual / Estimate FY 2009
$64,724,082	$98,282,261	$98,748,314

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part B
Section IV

STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS

STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS - PLANNING COUNCIL CHARGE, ROLE, & ACTIVITIES
LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

The State Mental Health Planning Council, originally established under PL 99-660 guidelines, is integrally involved in statewide planning and development of mental health services. The Council fully embraces the vision statement in the *President's New Freedom Commission Report (2003)* "*We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community."*

The Council is responsible for review of the annual Block Grant Application/ State Mental Health Plan together with Office of Mental Health (OMH) staff dedicated to this function. The current Planning Council includes 40 members consisting of consumers, family members of adults with serious mental illness, family members of children with emotional/ behavioral disorders, advocates, regional advisory council representatives, local governing entity representatives, and state agency employees. The Council is geographically representative of the state, and includes members from diverse backgrounds and ethnicities. The Planning Council includes four standing committees (Membership, Finance, Advocacy, and Programs and Services) that oversee each of the functions entrusted to the Council. Through the work of the membership as a whole, as well as through the committees, the Council is an active participant in transformation by addressing the Goals highlighted by the *New Freedom Commission Report* reproduced in the Table below. For example, the Advocacy Committee is specifically involved in ensuring that Goals #1, #2, #3, and #4 are addressed. Likewise, the Programs and Services Committee addresses Goals #2, #5, and #6.

The President's New Freedom Commission on Mental Health Goals In a Transformed Mental Health System	
Goal 1	Americans Understand that Mental Health Is Essential to Overall Health.
Goal 2	Mental Health Care Is Consumer and Family Driven.
Goal 3	Disparities in Mental Health Services Are Eliminated.
Goal 4	Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.
Goal 5	Excellent Mental Health Care is Delivered and Research Is Accelerated.
Goal 6	Technology Is Used to Access Mental Health Care and Information.

In addition to reviewing the Block Grant Application/ State Mental Health Plan, the Planning Council also monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. The Planning Council serves as an advocate for adults with serious mental illness, children with serious emotional disturbance, and other individuals with mental illness or emotional problems. This includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness throughout the state. The Planning Council continues to employ an official (professional) parliamentarian to serve as a protocol advisor for business meetings and committee work. The parliamentarian's assistance has significantly improved the structure and productivity of Planning Council meetings, and overall functioning.

Louisiana is currently in the process of a mental health care system change from geographic Regions under the direct administration of the Office of Mental Health (OMH) to a system of

independent health care districts or authorities, known as Local Governing Entities (LGEs). In the past, all Community Mental Health Clinics (CMHCs) and State hospital programs were operated by State civil servants with direct line of authority from the Office of Mental Health central office. Local Governing Entities are mandated as the local umbrella agencies to administer State-funded mental health, addictive disorder and developmental disability services in an integrated, seamless system within their localities. It is anticipated the LGEs will enable greater accountability and responsiveness to local communities, since they are based on local control and local authority. As of July 1, 2009, with the transition of Region 3 to South Central Louisiana Human Services Authority (SCLA), Louisiana now has five Local Governing Entities and five Regions.

As the Local Governing Entities take the place of Regions there is even more emphasis on the need for the development and sustainability of the Regional Advisory Councils (RACs) to address the needs of mental health at the local level. The RACs are similar in purpose to the Planning Council, but with interests specifically geared toward activities in their respective areas. The RACS are the lead agencies in advising how Block Grant funds will be allocated locally. Beginning in July 2007, each Regional Manager (or LGE Executive Director) has been directed by the OMH Assistant Secretary (Commissioner) to allocate a minimum of $5,000 yearly of Block Grant funding to their respective RACs to support the functioning of the Regional Advisory Councils. Regional managers have been instructed to work with the RACs to develop an annual budget. RAC membership is reflective of that of the Planning Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/ behavioral disorders, advocates, and state agency (Region or LGE) employees. The Planning Council Liaison has begun conducting onsite evaluations of the ten regions and local governing entities across the state to assure that they are viable, functioning organizations. The liaison is in the process of developing training that can be delivered via videoconferencing to allow for increased communication between the regions and LGEs, while increasing understanding of the role of the RAC and Planning Council.

The *Joint Block Grant Budget Review Committee* (JBGBRC), which was established by state policy in 2006 to monitor the expenditure of Block Grant funds, includes members of the OMH Planning Division, the OMH Fiscal Division, and the Finance Committee of the Planning Council. The committee is charged with overseeing Block Grant budget allocations and Intended Use Plans. During FY 2009, the Louisiana Block Grant was reduced by 11.7 percent, creating budgeting challenges throughout the state. The JBGBR committee was integral in the process of deciding how the budget reductions would be made within the Regions and LGEs.

A meeting took place between members of the Planning Council Finance Committee and OMH staff on February 10, 2009 to address increased efforts to allow monitoring of Block Grant contracts by Planning Council representatives. Although contract monitoring continues to be studied, the allocation of funds among the regions/ LGEs was once again a prominent topic of discussion. The OMH Assistant Secretary, Jennifer Kopke, supported the involvement of the Planning Council in studying possible scenarios for re-allocating block grant funds. In the past, Block Grant funds have been distributed based on the previous years' allocations, a practice rooted in a history that no longer has any real relevance. Initially, each Region was given a relatively proportionate share of the funds; with the exception of JPHSA, the first independently governed authority. JPHSA was the first Region to become a Local Governing Entity and was receiving much of its mental health funding through State General Funds. The management of JPHSA at the time chose not to participate in various Block Grant activities, and therefore chose not to be included in the initial allotment of Block Grant funds. Over time, as funding increased, JPHSA was given equal shares of the increases in funding. Current Planning Council members expressed dissatisfaction with the

methodology of the distribution of Block Grant funds, suggesting that there should be more specific guidelines at the regional/ LGE level for receiving funds. At the May, 2009 Planning Council meeting, a resolution was passed to appoint a special committee to make recommendations to the Assistant Secretary regarding the allocation formula for Block Grant funds.

The Special Committee first discussed the rationale for the reallocation and it was agreed to research and study possible options. Committee members were encouraged to review the impact of any reallocation from a *statewide* perspective representing the entire Planning Council, rather than viewing it from the standpoint of his or her individual Region/LGE. Chairman Jantz ultimately presented three possible scenarios for allocation of funds, and invited other suggestions and discussion. The three scenarios included:

- No change; continue with the same allocation process, rooted in history;
- Reallocation of funds based on population of the Region/ LGE;
- Reallocation of funds based on equal shares (i.e., total amount divided by 10).

Each of the two latter (reallocation) options was presented with an immediate impact statement reflecting the overall budget decrease or increase to each Region/LGE; as well as the impact as it would occur if spread out over 3 years or 6 years. Extensive discussion of the pros and cons of each scenario ensued. No other viable options were suggested; although in the future, the committee would like to see more information on performance outcomes, services, and persons served.

The committee members, with the authority of the full Planning Council, recommended re-allocating Block Grant funds by awarding each Region/LGE an equal percentage of the Block Grant funds. This choice was heavily influenced by the fact that the statewide impact (to any of the regions/ LGEs) would be less detrimental than allocating by population. Another factor that was considered was that the more rural regions, while not having as large a population, generally have more difficulty with access to services, transportation, and recruitment of staff. Additionally, funding based on population could vary significantly, particularly in a state that has already experienced much population shift due to hurricane displacement.

Members of the Special Committee also discussed the importance of Regional Advisory Councils (RACs) playing a more active role in initiating ongoing dialogue with their Regional Managers/Executive Directors. Some RACs are clearly more successful with this than others. The RACs ideally are in communication with Regional/ LGE leadership and contract monitors to support the use of best practices and funding programs that reflect the priorities of the Planning Council. It is through this personalized local / regional partnership that the Council can ensure that consumers are receiving the necessary access to services and best quality of care.

The Assistant Secretary took the Special Committee's recommendation under advisement, and decided to accept their recommendation. Therefore, on June 29, 2009 a memo was sent to each Regional Manager and LGE Executive Director informing them of the reallocation that would take place gradually over three years, beginning with the 2011 Block Grant. Changes are outlined in Appendix A.

The activities presented above highlight the interactive and valuable relationship between the Planning Council and the Office of Mental Health. The Planning Council's membership is listed below, along with the duties, responsibilities, role and charge as described in the Planning Council By-Laws and Rules:

Louisiana Mental Health Planning Council
Membership List – 2009 - 2010

Revised –08-03-09

KEY (By Federal Regulation, ALL MEMBERS must be categorized according to these groupings):					
State Employee	**Consumers/ Survivors/ Ex-patients**	**Family Members of Children with SED**	**Family Members of Adults with SMI**	**Others (Not state employees or providers)**	**Providers**

Agency/ Org. Represented	#	Name	Type of Membership	Address, Phone & Fax/ Email
STATE AGENCY MEMBERS MANDATED BY FEDERAL REGULATION.				
Office of Mental Health	1	Darling, Ann	State Employee	Office of Mental Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-2563 (work) 225-342-1984 (Fax) Ann.Darling@LA.Gov
Education	2	Schaff, Robert	State Employee	La Department of Education 1201 N. 3rd Street, 4th Floor P.O. Box 9064 Baton Rouge, LA 70804-9064 225-219-0367 225-219-4454 (Fax) Robert.Schaff@La.Gov
Vocational Rehabilitation	3	Martin, Mark	State Employee	La Rehabilitation Services 3651 Cedarcrest Baton Rouge, LA 70816 225-295-8900 225-295-8966 (Fax) MMartin@dss.state.la.us
Housing	4	Brooks, Barry E.	State Employee	LA Housing Finance Agency 2415 Quail Drive Baton Rouge, LA 70808 225-763-8773 225-763-8749 (Fax) BBrooks@LHFA.state.la.us
Department of Social Services	5	Sam, Rose	State Employee	Office of Community Services 627 N. 4th Street POB 3318 Baton Rouge, LA 70821 225-342-6509 225-342-0963 (Fax) RSam1@dss.stae.la.us

Criminal Justice	6	Larisey, Sue	State Employee	Dep't of Public Safety & Corrections 660 N. Foster Drive Baton Rouge, LA 70806 225-922-1300 225-291-9349 (Fax) Sue.Larisey@La.Gov
STATE AGENCY MEMBERS INVOLVED IN DEVELOPMENT OF BLOCK GRANT PLAN				
State Planner	7	Castille, Dr. Cathy	State Employee	Office of Mental Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-9528 225-324-1984 (Fax) Cathy.Castille@LA.Gov
Child State Planner	8	Lemoine, Dr. Randall	State Employee	Office of Mental Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-9528 225-324-1984 (Fax) Randall.Lemoine@LA.Gov
STATE AGENCY MEMBERS MANDATED IN STANDING RULES				
Medicaid	9	Brown, Pamela G.	State Employee	Bureau of Health Services Financing POB 91030 628 N. 4th Street Baton Rouge, LA 70821-9030 225-342-6255 225-376-4662 (Fax) Pamela.Brown@LA.Gov
Alcohol & Drug Abuse	10	Beck, Michele	State Employee	Office for Addictive Disorders 628 N. 4th Street P.O. Box 3868 Baton Rouge, LA 70821 225-342-9354 225-324-3931 (Fax) Michele.Beck@La.Gov
Developmental Disabilities	11	Greer, Dr. Amy	State Employee	Office for Citizens with Developmental Disabilities 628 N. 4th Street POB 3117 Baton Rouge, LA 70821-3117 225-342-0095 225-342-8823 (Fax) Amy.Greer2@La.Gov

Office of Public Health	12	Wightkin, Dr. Joan	State Employee	Maternal and Child Health Program 1010 Common St. Suite 2710 New Orleans, LA 70112 504-568-3506 504-568-3503 (Fax) Joan.Wightkin@La.Gov
ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES				
Meaningful Minds of Louisiana	13	Glover, Carole	Other (not state employee or provider)	1345 S. Willow St. #13 Lafayette, LA 70506 337-234-6291 CGlover211@bellsouth.net
Louisiana Federation of Families for Children's Mental Health	14	Bell, Maria	Other (not state employee or provider)	5627 Superior Dr. Suite A-2 Baton Rouge, LA 70816 225-293-3508 225-293-3510 (Fax) MBell@laffcmh.org
National Alliance on Mental Illness - Louisiana	15	Jantz, Jennifer Council Chair	Other (not state employee or provider)	5700 Florida Blvd., Suite 320 P.O. Box 40517 Baton Rouge, LA 70835-40517 225-926-8770 225-926-8773 (Fax) namilajj@bellsouth.net namilouisiana@bellsouth.net
Mental Health America of Louisiana	16	Thomas, Mark	Other (not state employee or provider)	660 N. Foster Drive, Suite C - 201 Baton Rouge, LA 70806 225-201-1930 225-201-1949 (Fax) MThomas@mhal.org
AARP Louisiana	17	Boling, John	Other (not state employee or provider)	3264 Seracedar Street Baton Rouge, LA 70-815 225-293-9824 JRBoling@cox.net
The Extra Mile	18	Turner-Larry, Tonya	Family Member of Child with SED	122 Raymond Drive Monroe, LA 71203 318-388-6088 318-388-6872 (Fax) theextramile@bellsouth.net

REGIONAL ADVISORY COUNCIL REPRESENTATIVES These individuals are either RAC Chairs or other representatives from the RAC One person per Region/ LGE				
MHSD	19	Miller, Rev. Donald Council Vice Chair	State Employee	5120 Easterly Circle New Orleans, LA 70128 985-626-6318 985-626-6640 (Fax) Donald.Miller@La.Gov
CAHSD	20	Jack, Nina	Other (not state employee or provider)	2124 Wooddale Blvd. Baton Rouge, LA 70806 225-925-2372 (work) 225-317-1246 (cell) NJack@voagbr-clvs.org
Region 3	21	Martin, Brenda P.	Consumer/ Survivor/ Ex-patient	217 North French Quarter Houma, LA 70364 985-580-3352 985-876-8897 Brenda.Martin@La.Gov
Region 4	22	Nobles, Denver	Consumer/ Survivor/ Ex-patient	P.O. Box 1264 Scott, LA 70583 337-849-6764 lafayetteredneck@yahoo.com
Region 5	23	Griffin, Carolyn B.	Family Member of Adult with SMI	2700 General Moore Ave. Lake Charles, LA 70615 337-477-8897 cargri@suddenlink.net
Region 6	24	Dennis, Jr. Victor B.	Other (not state employee or provider)	257 Stilley Road Pineville, LA 71360-5934 318-473-2273 318-623-4547 (cell) vdennisj@bellsouth.net
Region 7	25	Bradley, Debra	Consumer/ Survivor/ Ex-patient	934 Unadilla Street Shreveport, LA 71106 318-868-6964 318-564-2853 DBradl6@bellsouth.net
Region 8	26	Perry, Kathy	Consumer/ Survivor/ Ex-patient	2005 Roggerson Road, Apt. B Monroe, LA 71201 318-855-6059 318-914-3162 Kdp432001@yahoo.com
FPHSA	27	Richard, Nicholas	Family Member of Child with SED	100 Saint Anne Circle Covington, LA 70433 985-626-6538 (w) 877-361-1631 (fax) nrichard@namisttammany.org
JPHSA	28	Noble, Rubye	Family Member of Adult with SMI	POB 8857 Metairie, LA 70011 504-835-5427 504-835-5424 (fax) rubyenoble@ren.nocoxmail.com

INDIVIDUAL REPRESENTATIVES These individuals <u>can</u> be on the RAC, but do not have to be. <u>One person per Region/ LGE</u>				
MHSD	29	Jenkins, Seton	State Employee	4408 Henican Place Metairie, LA 70003 504-400-0157 504-568-3138 (Fax) Seton.Jenkins@La.Gov
CAHSD	30	Mong, Stanley	State Employee	4615 Government Street Baton Rouge, LA 70806 225-925-1768 225-922-2175 (Fax) Stanley.Mong@La.Gov
Region 3	31	Jones, Maletta	Family Member of Child with SED	6907 Alma Street Houma, LA 985-876-8875 985-857-3743 MLJones@Mail.La.Gov
Region 4	32	Mullen, Joy	Consumer/ Survivor/ Ex-Patient	111 Paige Street Duson, LA 70529 337-988-4043 337-349-7417 Joy4recovery@cox.net
Region 5	33	McMahon, LaShanda	Family Member of Child with SED	POB 103 Fenton, LA 70640 337-756-9210 lashandam@centurytel.net
Region 6	34	Cobb, Cynthia	Family Member of Child with SED	POB 5334 Alexandria, LA 71307 318-484-6264 (w) 318-443-1554 (h) Ccobblaff6@yahoo.com
Region 7	35	Davis, Gloria	Family Member of Child with SED	6299 Carrol Circle Shreveport, LA 71107 318-868-6964 Davi6814@bellsouth.net
Region 8	36	Bias, Yolanda	Family Member of Child with SED / (and) Consumer/ Survivor/ Ex-patient	343 Huenefeld Rd., Apt. A5 Monroe, LA 71203 318-388-6088 318-388-6872 (Fax) kayeextramile@yahoo.com
FPHSA	37	Gutowski, Cindy	State Employee	FPHSA POB 8630 Mandeville, LA 70470 985-626-6488 985-626-6368 (Fax) Cindy.Gutowski@La.Gov
JPHSA	38	Baudry, Clay	Family Member of Child with SED	3229 Iowa Avenue Kenner, LA 70065 504-443-4156 504-443-7679 (Fax) Zerod@earthlink.net

INDIVIDUAL MEMBERS AT-LARGE				
At-large (CAHSD)	39	Kauffman, Steve	Consumer/ Survivor/ Ex-Patient	Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) skauffman@advocacyla.org
At-large (Region 5)	40	Raichel, Clarice	Family Member of Adult with SMI	POB 1824 Lake Charles, LA 70602 337-433-0219 337-433-1860 (fax) namiswla@bellsouth.net

Planning Council Support Staff

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Louisiana Mental Health Planning Council
Composition by Type of Member – 2009 – 2010
Revised 08/03/09

Type of Membership	Number & Percentage of Total Membership
TOTAL MEMBERSHIP	**40 # 100 %**
Consumers/ Survivors/ Ex-patients (C/S/X)	**6**
Family Members of Children with SED	**8**
Family Members of Adults with SMI	**3**
Vacancies (C/S/X & family members)	**0**
Others (not state employees or providers)	**7**
Total C/S/X, Family Members & Others	**24 # 60 %**
State Employees	**16**
Providers	**0**
Vacancies	**0**
Total State Employees & Providers	**16 # 40 %**

Notes:
1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council. Percentage of family members of children with SED to total members 8/40 = 20%.

2) State employee and provider members shall not exceed 50% of the total members of the Planning Council. Percentage of state employees and providers 16/40 = 40 %.

3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support activities.

4) Membership is equally divided among the 10 Geographic Regions/ LGEs of the State, generally with two representatives from each Region/ LGE.

5) The council is committed to working towards diversity, and consideration is given towards representation of diverse groups in representation on the council

Article I: NAME

The name of this organization shall be: *Louisiana Mental Health Planning Council* (herein: "council")

Article II: OBJECT

The object of the council shall be to serve the state of Louisiana as the mental health planning council provided for under 42 U.S.C. 300x-3 (State mental health planning council) and to exercise the following duties in connection therewith:

1. To review plans provided to the council pursuant to 42 U.S.C. 300x-4(a) by the state of Louisiana and to submit to the state any recommendations of the council for modifications to the plans;
2. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Article III: MEMBERSHIP

Section 1. Statutory Requirements.

A. The council shall be composed of residents of the state of Louisiana, including representatives of:

   1. The principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and the state agency responsible for the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);
   2. Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
   3. Adults with serious mental illnesses who are receiving (or have received) mental health services; and
   4. The families of such adults or families of children with emotional disturbance.
   5. With respect to the membership of the council, the ratio of parents of children with a serious emotional disturbance to other members of the council is sufficient to provide adequate representation of such children in the deliberations of the council.

B. At least 50 percent of the members of the council shall be individuals who are not state employees or providers of mental health services.

Section 2. Classes of Membership.

Membership on the council shall be of two classes: Individual and Organizational.

1. Individual members shall be those persons who are not representatives of a state agency or a public or private entity.
2. Organizational members shall be those persons appointed from state agencies or a public or private entity.

Section 3. Composition.

A. The council shall be composed of not more than 40 members.
B. Members shall be those persons whose applications for membership are approved by the council.

Section 4. Term of Service.

A. Term of service for members shall be four years. A member who has served two

consecutive terms shall not be qualified for membership until the lapse of one year. Ex officio members shall not be term limited.

B. In the event of the death, resignation, removal, or loss of qualification for membership, the council shall fill the vacancy thus created with a properly qualified person to serve for the duration of the former member's term.

C. A member may be removed from the council by a majority vote with notice, a two-thirds vote without notice, or a majority of the entire membership.

Article IV: OFFICERS

Section 1. Officers.

Officers shall be a chairman, a vice chairman, and a secretary. The chairman and vice chairman shall be members of the council.

Section 2. Duties.

Officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the council.

A. Chairman. The chairman shall preside at meetings of the council. The council, however, may suspend this provision and elect a chairman pro tempore at any meeting. The chairman shall appoint all standing and special committees except that nothing shall prohibit the council from appointing special committees on its own motion. The chairman may appoint persons who are not members of the council to serve on any committee the chairman is authorized to appoint. The chairman shall be ex officio a member of all committees except the nominating committee, and shall have such other powers and duties as the council may prescribe.

B. Vice chairman. The vice chairman shall serve as chairman of the committee on membership and shall perform such other duties as the council may prescribe. In the absence of the chairman from a meeting, the vice chairman shall preside unless the council elects a chairman pro tempore.

C. Secretary. The secretary shall be the custodian of the records of the council and shall keep or cause to be kept a record of the minutes of the meetings of the council. The secretary shall maintain an indexed book containing all standing rules adopted by the council. The secretary shall also be the custodian of the council seal, and shall attest to and affix said seal to such documents as may be required in the course of its business. The secretary may appoint an assistant secretary who shall be authorized to fulfill the duties under the direction and authority of the secretary.

Section 3. Nomination and Election.

A. The council shall elect officers at the regular meeting in the last quarter of each even numbered year.

B. At the regular meeting immediately preceding the election meeting, the council shall elect a nominating committee of three members. It shall be the duty of this committee to nominate candidates for the offices to be filled. The nominating committee shall report its nominees at the election meeting. Before the election, additional nominations from the floor shall be permitted.

C. In the event of a tie, the winner may be decided by drawing lots.

Section 4. Term of Office.

Officers shall serve for two years or until their successors are elected and assume office. Officers shall assume office at the end of the meeting at which they are elected.

Section 5. Removal from Office.

The council may remove from office any officer at any time.

Section 6. Vacancy.

A. In the event of a vacancy in the office of chairman, the vice chairman shall succeed to the office of chairman.

B. In the event of a vacancy in the office of vice chairman or secretary, the chairman may appoint a temporary officer to serve until the council elects a replacement.

Article V: MEETINGS

Section 1. Regular Meetings.

A. Regular meetings of the council shall be held on the first Monday of the second month of each calendar quarter. The council may reschedule its next regular meeting at any regular or special meeting.

B. Should a regular meeting date fall on or within three days of a state holiday, the executive committee may reschedule the meeting subject to the notice provisions required for special meetings.

Section 2. Special Meetings.

Special meetings may be called by the chairman and shall be called upon the written request of a majority of the members. The purpose of the meeting shall be stated in the call.

Section 3. Notice of Meetings.

A. Notice of the hour and location of regular meetings, and notice of any change in the date, time, or place of any regular meeting shall be sent in writing to the members at least ten days before the meeting.

B. Notice of special meetings of the council shall be sent at least ten days before the date of the meeting. The notice shall state the purpose of the meeting. In the event the secretary fails to issue, within a reasonable time, a special meeting call on the request of members of the council, the members who petitioned for the call may schedule the special meeting and issue the call and notice at the expense of the council.

Section 4. Quorum.

A quorum shall consist of twelve members.

Article VI: COMMITTEES

Section 1. Executive Committee.

A. Composition. The chairman of the council shall be the chairman of the executive committee. The vice chairman, the secretary, and an OMH state block grant planner shall be members of the executive committee.

B. Duties and Powers. The executive committee shall, to the extent provided by resolution of the council or these bylaws, have the power to act in the name of the council. The executive committee shall fix the hour and place of council meetings, make recommendations to the council and perform such other duties as are specified in these bylaws or by resolution of the council. But, notwithstanding the foregoing or any other provision in these bylaws, the executive committee shall not have the authority to act in conflict with or in a manner inconsistent with or to rescind any action taken by the council; to act to remove or elect any officer; to establish or appoint committees or to name persons to committees; to amend the bylaws; to authorize dissolution; or, unless specifically authorized by a resolution of the council, to authorize the sale, lease, exchange or other disposition of any asset of the council, and in no event shall it make such disposition of all or substantially all of the assets of the council.

C. Meetings. The executive committee shall meet on the call of the chairman or the three other members. Notice of at least 24 hours shall be given for any meeting of the executive committee. Executive committee members may at any time waive notice in writing and consent that a meeting be held. The executive committee is authorized to meet via teleconference or videoconference provided that all members in attendance can hear each other. A quorum of the executive

committee shall be a majority of its membership.

Section 2. Standing Committees.

A. The chairman of the council shall appoint the following committees:

1. Committee on Advocacy. The committee on advocacy shall report and recommend on matters involving the mental health advocacy program of the council.
2. Committee on Finance. The committee on finance shall report and recommend on matters affecting the mental health block grant funds and the council operating budget.
3. Committee on Membership. The committee on membership shall report and recommend on matters involving the membership recruiting and composition of the council.
4. Committee on Programs and Services. The committee on programs and services shall report and recommend on matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state.

B. A state block grant planner shall be ex officio a member of each standing committee.

Section 3. Duties and Powers of Standing Committees.

The council shall establish such specific duties and authority for each standing committee as necessary to carry on the work of the council.

Section 4. Other Committees.

Such other committees, standing or special, may be appointed by the chairman or by the council as may be necessary to carry on the work of the council.

Article VII: PARLIAMENTARY AUTHORITY

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the council in all cases to which they are applicable and in which they are not inconsistent with these bylaws, any special rules of order the council may adopt, and any statutes applicable to the council that do not authorize the provisions of these bylaws to take precedence.

Article VIII: AMENDMENT

These bylaws may be amended at any council meeting by a two-thirds vote, provided that the amendment has been submitted in writing at the previous regular meeting or notice of the proposed amendment is mailed to the members at least 21 days but no more than 30 days before the meeting at which the proposed amendment is to be considered. Additionally, in the case of a special meeting, notice of the proposed amendment shall be included in the call.

CERTIFICATE

I, Melanie Roberts, Secretary of the Louisiana Mental Health Planning Council, certify that the foregoing bylaws of the council are those as amended on August 4, 2008 at a regular meeting of the council.

Melanie Roberts
Secretary

STANDING RULES

MEMBERSHIP COMPOSITION

SECTION 1. NUMBER OF MEMBERS

The number of council members shall be 40.

SECTION 2. COMPOSITION OF THE COUNCIL

The membership composition of the council shall be as follows:

A. Organizational members

1. Appointed from state agencies

a. Two members from OMH responsible for the preparation of the block grant plan.

b. Six members from state agencies as mandated by federal law, one from each of the following:

(1) DHH Office of Mental Health (OMH)

(2) Louisiana Department of Education (LDE)

(3) DSS Louisiana Rehabilitation Services (LRS)

(4) Louisiana Housing Finance Agency (LHFA)

(5) Department of Social Services (DSS)

(6) Department of Public Safety and Corrections (DPS&C)

c. Four other members from state agencies as follows:

(1) DHH Bureau of Health Services Financing (Medicaid)

(2) DHH Office for Addictive Disorders (OAD)

(3) DHH Office for Citizens with Developmental Disabilities (OCDD)

(4) DHH Office of Public Health (OPH)

2. Appointed from mental health advocacy organizations:

Six members, one from each of the following:

(1) Meaningful Minds of Louisiana

(2) Louisiana Federation of Families for Children's Mental Health

(3) National Alliance on Mental Illness – Louisiana

(4) Mental Health America of Louisiana

(5) American Association of Retired Persons in Louisiana (AARP LA)

(6) The Extra Mile

3. Appointed from OMH regional advisory councils (RAC):

Ten members, one from each RAC.

B. Individual Members

Ten members, one from each OMH Region or local governing entity (LGE).

Two members from the state at-large.

SECTION 3. QUALIFICATIONS

Council members shall fall into one or more of the following categories in order to be considered qualified for service on the council:

1. Adults with serious mental illness who are receiving or who have received mental health services, or
2. Family members of adults with serious mental illness, or
3. Children and youth with serious emotional/behavioral disorders who are receiving or have received mental health services and related support services, or
4. Parents and family members of children/youth with a serious emotional/ behavioral disorder, or
5. Advocates for the severely mentally ill, or

6. Individuals, including providers, who are concerned with the need, planning, operation, funding, and use of mental health services and related support services.

Adopted November 5, 2007

NON-DISCRIMINATION POLICY

The council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy and parenthood, custody of a minor child, or physical, mental, or sensory disability.

Revised November 5, 2007

AUTHORIZED REPRESENTATIONS

1. The council may officially represent itself, but not the office of mental health, the state of Louisiana, any state agency, or any individual member in any matter concerning or related to the council.
2. No council member shall make representations on behalf of the council without the authorization of the council.

Revised November 5, 2007

COUNCIL AGENDA

1. The secretary shall prepare an agenda for each council meeting. Council members may submit motions in advance for placement on the agenda for consideration under the appropriate order of business. Officers and committees reporting recommendations for action by the council shall submit the recommendations to the secretary at least 10 days before the meeting for entry on the agenda. The tentative agenda for all regular meetings will be available to all council members at least five (5) days prior to each council meeting. The secretary shall distribute the tentative agenda in advance to any member who requests it by the method requested by the member.
2. Nothing contained in this rule shall prohibit the council from considering any matter otherwise in order and within its object at any regular meeting.

Revised November 5, 2007

SPECIAL RULES OF ORDER

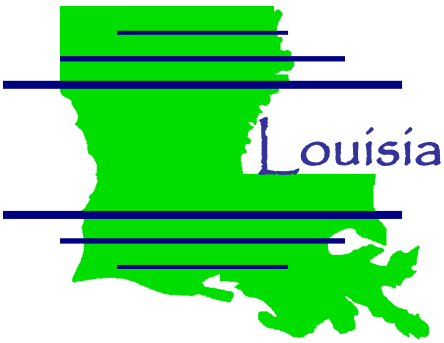
ADOPTED NOVEMBER 5, 2007

ATTENDANCE

At the first regular council meeting after the second consecutive absence of a council member, the executive committee shall report its recommendation on the question of retention or removal of the member from the council.

PUBLIC COMMENT

1. At any time the council considers a matter on which a member of the public wishes to address the council, the council shall make reasonable efforts to provide the opportunity to a representative number of proponents and opponents on each issue before the council.
2. Each person appearing before the council shall be required to identify himself and the group, organization, or company he represents, if any, and shall notify the chairman no later than the beginning of the meeting by completing a basic information form furnished by the secretary.
3. To be certain that an opportunity is afforded all persons who desire to be heard, the chairman shall inquire at the beginning of any period of public comment on each matter if there are additional persons who wish to be heard other than those who have previously notified the chairman.
4. Subject to such reasonable time limits the council may establish for any public hearing or period of public comment, the chairman shall allot the time available for the hearing in an equitable manner among those persons who are to be heard. In no case, however, shall any person speak more than five minutes without the consent of the council.



Louisiana Mental Health Planning Council

August 12, 2009

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

Dear Ms. Orlando:

The Louisiana Mental Health Planning Council (LMHPC) has been given an opportunity to review and comment on the Center for Mental Health Services (CMHS) Community Mental Health Services Block Grant Application for the fiscal year 2009-10. The quarterly meeting of the LMHPC was held on August 3, 2009. At this meeting, the membership participated in a formal review of the plan, with an emphasis on the Goals, Targets, and Indicators. Discussion and feedback was welcomed by the Office of Mental Health (OMH). The Plan has been available on the LMHPC listserv for review by the Planning Council members. Feedback on the goals and activities of the Office of Mental Health as well as other mental health programs throughout the state has been favorable.

Members of the LMHPC continue to applaud OMH for including them in decisions, particularly those that have involved fiscal matters, especially important in this tense economic climate. Our members who serve on the Council and various committees of the Council have dedicated themselves to monitoring expenditures of the Block Grant funds, and to encouraging the use of evidence-based practices to assure that Louisiana consumers are receiving the best quality of care.

We as a Council believe that the plan is increasingly responsive to the needs identified in the *President's New Freedom Commission Report*, and serves as a guidepost in efforts to transform the mental health system in the state.

Sincerely,

Jennifer Jantz
Jennifer Jantz, Chair
Louisiana Mental Health Planning Council
Executive Director,

5700 Florida Boulevard, Suite 320
Baton Rouge, Louisiana 70806

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part C
STATE PLAN
Section I

Adult & Child/ Youth

Description of the State Service System

SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
OVERVIEW, REGIONAL RESOURCES, LEADERSHIP
LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

INTRODUCTORY COMMENTS

There are many challenging factors influencing the mental health system in Louisiana today. The tragedy and devastation experienced by the State in the form of Hurricanes Katrina and Rita in 2005 will affect all Louisiana residents for decades. Although not as severe in terms of numbers of people affected, two major hurricanes again hit Louisiana in 2008. Hurricane Gustav made landfall three days after the Block Grant Plan was submitted, reflecting eerily on the history of having Katrina hit three days after the Plan was submitted in 2005. Hurricane Gustav made a direct hit the capital city of Baton Rouge, effectively dealing a blow to the governmental sector. The Department of Health and Hospitals building in which the administration of the Office of Mental Health is housed, was operated on emergency generator power for several days following the storm. Electrical power was out to *more than 90% of the city* following the storm, and many homeowners and businesses were without power for 3-4 weeks. On the heels of Gustav, Hurricane Ike affected the area of the state that had previously been devastated by Hurricane Rita in 2005. While the southern region of the state sustains the most direct damage each time a hurricane hits, the entire state continues to experience the repercussions of these storms, both emotionally and financially. Louisianians are by nature a resilient group, and progress is being made towards recovering from these natural disasters. However, it would be inaccurate to say that the state is anywhere near having recovered from the crisis created by the hurricanes, particularly now that there is also a budgetary crisis to deal with. As stated in the *President's New Freedom Commission on Mental Health Report*:

Recovery is the Goal of a Transformed System.

Over the last several years, it has become imperative to constantly re-evaluate priorities; including Block Grant goals, targets and indicators that had been previously established, in order to realistically reflect the capabilities of a strained and in some cases a temporarily incapacitated system. The fiscal realities that Louisiana is experiencing both as the consequence of hurricanes and the national economy are of concern; and the effects long term are simply not predictable with any measure of certainty. Fortunately, we do believe in the principle that *people recover*. The FY 2010 Block Grant Application is presented in the context of, and with an awareness of the aftermath of the storms. It is impossible to discuss most areas of the plan without reference to the effects of the storms and the legacy that these hurricanes have left for the State and its citizens.

OVERVIEW OF MENTAL HEALTH SYSTEM IN LOUISIANA

The Office of Mental Health (OMH) operates within the Department of Health and Hospitals (DHH) alongside agencies of the Office of Public Health, the Office for Addictive Disorders, the Office for Citizens with Developmental Disabilities, the Office of Management and Finance (including the State Medicaid agency), and the Office of Aging and Adult Services. The Office of Mental Health is governed by the Assistant Secretary (e.g., Commissioner) of Mental Health who is the appointing authority for the agency, and reports to the Secretary of the Department of Health and Hospitals.

In order to assist the reader in understanding the State mental health care system, a map of Louisiana that illustrates the geographic Regions or Local Governing Entities (LGEs), and organizational charts of OMH and DHH are included in this section. It should be noted that the Mental Health Planning Council occupies a prominent place in the formal OMH organizational chart. The OMH organizational chart will remain provisional until it changes with the new Office of Behavioral Health, as is discussed in a later paragraph. Since 2004 the Planning Council Liaison has acted as an important and effective link between the Planning Council and OMH. Strategic planning ensures that the goals and objectives of the OMH and the plans for transformation are carried out according to the *President's New Freedom Commission Report*.

State Agency Leadership & Description of Regional Resources

The Office of Mental Health (OMH) is the state agency currently responsible for planning, developing, operating, and evaluating public mental health services for the citizens of the State. The Office of Mental Health services are targeted to adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness. While there is no separate state-wide division for Children's services, the Division of *Child / Youth Best Practices* occupies a prominent position in the functioning of the Office of Mental Health as is noted within the organizational chart. The expectation is that Regions and LGEs will maintain Regional Advisory Councils officially linked to the State Planning Council in order to receive Block Grant funding.

Legislation has mandated that the administration of the Louisiana mental health care system change from interrelated geographic *Regions* to a system of independent health care Districts or Authorities (also referred to as *Local Governing Entities or LGEs)* under the general administration of OMH. As of July, 2009, there are five LGEs in operation and five that continue to operate as Regions. The remaining Regions are evaluating their readiness to become LGEs, and the transition to LGEs is expected to be complete by the year 2011. With the movement towards more LGEs comes the importance of developing mechanisms to assure continuity of care and consistency of statewide standards of care that are responsive to needs of consumers.

In the past, the Community Mental Health Clinic (CMHC) and State Hospital programs were all directly operated by state civil servants with direct line of authority from the OMH central office. The LGEs are (and will be) legislatively mandated as the local umbrella agencies that administer the state-funded mental health, addictive disorder and developmental disability services in an integrated system within their localities. The LGE model affords opportunity for greater accountability and responsiveness to local communities since it is based on local control and local authority. Each LGE is administered by an Executive Director who reports to a local governing board of directors of community and consumer volunteers. All local governing entities remain part of the departmental organizational structure, but not in a direct reporting line with OMH. The Office of Mental Health maintains requirements for uniform data reporting through memoranda of agreement arrangements supported by the Department of Health and Hospitals.

In wide sweeping legislation, the 2009 Regular Session of the Louisiana legislature, passed into law ACT No. 384 creating the Office of Behavioral Health. ACT 384 dissolves the Office of Mental Health and the Office for Addictive Disorders, and merges the administration and planning functions of each office into one. This move was made in order to allow for best practices in the treatment of individuals with mental illness, addictive disorders, and co-occurring disorders, while

maximizing available funding. An implementation advisory committee is in the process of convening to make recommendations concerning the implementation of this law, and will make a report to the Secretary of DHH no later than January 31, 2010. The advisory committee consists of 12 people representing consumers, advocates and professionals; with equal representation from the mental health and addictions communities. The legislation requests that the Planning Council submit a list of consumers who would be willing to serve on this committee. Among other tasks, the committee is charged with making the following recommendations:

- procedures and time lines for the initial year of the merger;
- consolidated administrative structure;
- mission and vision statement;
- performance measures with expected outcomes; and
- general operational mechanisms.

With time, the consolidation of the administration of the offices of mental illness and addictive disorders into the Office of Behavioral Health will offer less redundancy and greater benefits to Louisiana citizens in need of these services. It is also anticipated that in the future, the merger will lead to a strengthening of the link to primary care.

With the transition to local governing entities, the role of the Office of Behavioral Health (OBH) will also transition to provide resources and assistance that enables the LGEs to carry out service delivery. In addition, OBH will ensure that the LGE service system is well coordinated with those services that will continue to be operated by the State (primarily the State-operated psychiatric hospitals). OBH will also be responsible for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing mechanisms statewide for measuring outcomes. With the trend towards more local governing entities comes the importance of developing mechanisms to assure continuity of care and consistency of standards of care that are responsive to needs of consumers. Legislation has established roles and accountability mechanisms for DHH's relationship with LGEs.

The first local Governing Entity, the Jefferson Parish Human Service Authority, has operated all public mental health, substance abuse, and developmental disability services for that parish since 1989. A second LGE, the Capital Area Human Service District, was authorized by the legislature in 1998. This LGE includes several parishes, and integrates mental health, substance abuse, developmental disability, and public health services in one regional system of care. Two LGEs became operational in July of 2004, the Florida Parishes Human Services Authority and the Metropolitan Human Services District. The South Central Louisiana Human Services Authority (Region 3) is officially transitioning from a Region to an LGE beginning on July 1st of 2009.

Two clinics in the New Orleans area remain closed as a result of damage associated with of the storms; these clinics have been replaced with more community based services. There are currently a total of 43 Community Mental Health Clinics (CMHCs), and 27 Outreach locations that are operational in the State. The CMHCs provide an array of services including crisis services, screening and assessment, individual evaluation and treatment, psychopharmacology, clinical casework, specialized services for children and youth, and in some areas, specialized services for those in the criminal justice system and for persons with co-occurring mental and addictive disorders. OMH also provides additional community-based services either directly or through

contractual arrangements, including supported living, supported employment, family/ consumer support services (e.g., case management, respite, drop-in centers, consumer liaisons), and school based mental health services. OMH (including the LGEs) has many contracts with private agencies, funded by the Block Grant to provide a wide array of additional community-based services. OMH has operated as a managed care agent of the state Medicaid agency to authorize and monitor quality and outcomes for mental health rehabilitation services operated through private Medicaid provider agencies statewide. However, as of July 1, 2009, the Mental Health Rehabilitation program has been moved out of OMH and now operates under the Bureau of Health Services Financing/ Medicaid Services, within DHH.

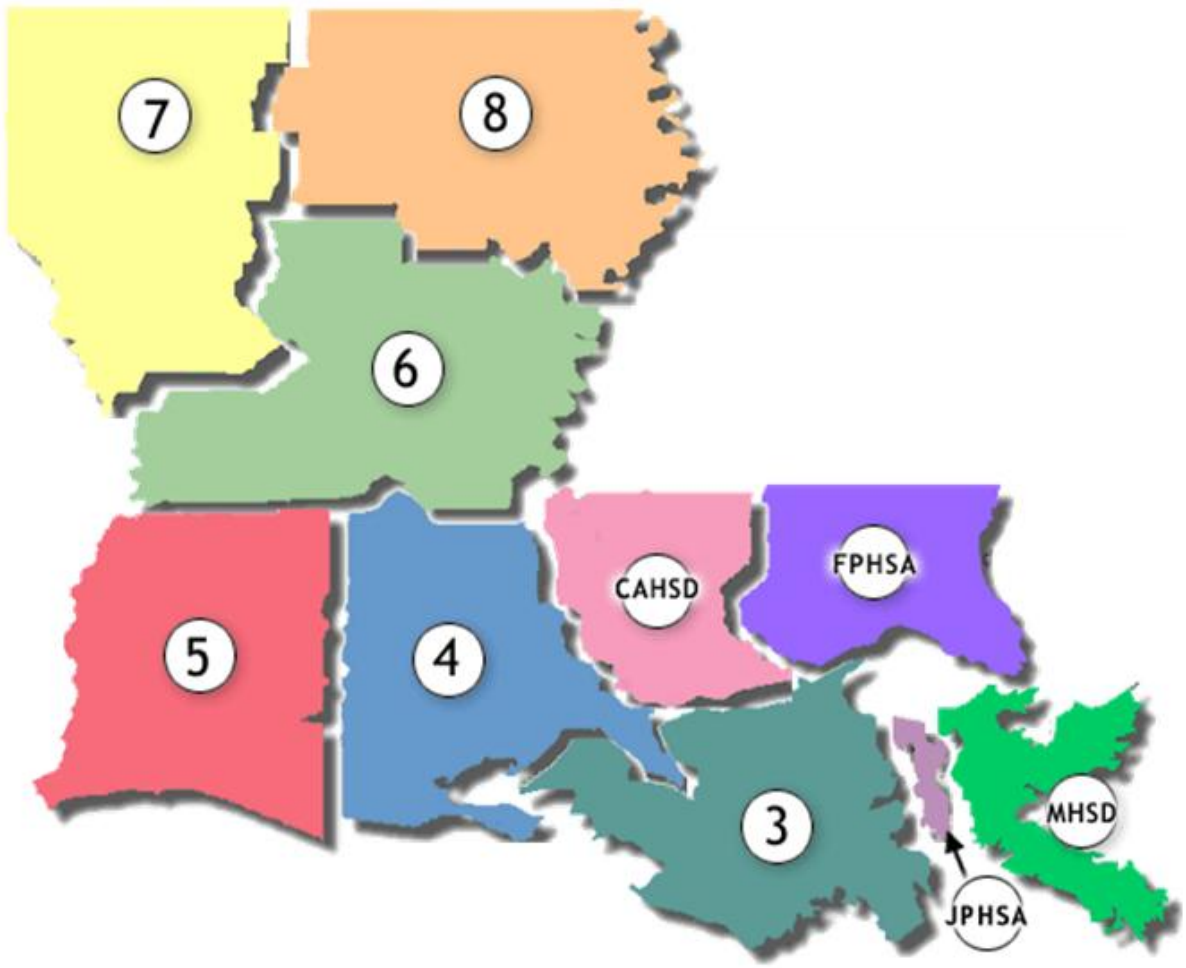
There are three state-operated intermediate/long term inpatient care psychiatric hospitals that have a total of 364 Adult Civil Intermediate care beds: Southeast Louisiana Hospital (SELH) in Mandeville, Eastern Louisiana Mental Health System (ELMHS) in Jackson and Greenwell Springs, and Central Louisiana State Hospital (CLSH) in Pineville. Three hospitals serve children and youth: New Orleans Adolescent Hospital (NOAH), Central Louisiana State Hospital, and Southeast Louisiana Hospital. One hospital (ELMHS) includes a division that is solely designated for the treatment of the forensic population; this setting has a total of 379 adult (intermediate) forensic beds. New Orleans Adolescent Hospital historically treated solely children and adolescents; however, in response to the loss of bed capacity in New Orleans due to Hurricane Katrina, NOAH was modified to include 12 adult acute beds. Ten beds remain dedicated to children and adolescents at NOAH. Statewide, there are 61 beds dedicated to Children/ Youth. There are also currently a total of eight facilities in the state that are operated by the Louisiana State University Medical schools that have acute mental health beds. The total number of acute beds within the state is 311. For a more detailed picture of the bed count across the state, see Criterion 5, Table *State Psychiatric Facilities Statewide Staffed Beds*.

OMH provides for a continuum of care process to facilitate access to acute and/or intermediate/ long-term hospital placements. However, the demand for available inpatient services continues to exceed the number of available hospital beds due in part to infrastructure changes that unavoidably occurred following the 2005 hurricanes (Katrina and Rita).

In keeping with System of Care principles and the need for a comprehensive continuum of care, the Office of Mental Health has improved the array of community based services operated through the hospitals and geographic Regions. Persistent efforts have been successful in establishing more community-based services operated through the hospitals (e.g., day hospitals, rehabilitation programs). The community and hospital system of care emphasize continuity of care and treatment in the least restrictive environment appropriate to the person's needs. There is an emphasis on a close liaison between the regional service system, the LGEs, state hospitals, community provider agencies, and consumer and family support and advocacy systems. OMH supports consumer and family involvement in the planning, development, delivery, and evaluation of services. OMH provides funding for regional consumer resource centers, various family support programs, and regional consumer liaisons. OMH also trains and employs consumer and family members and parents of emotionally disturbed children as quality of service evaluators. OMH has developed a Vision and Mission that guide the administration and day-to-day provision of services. It is anticipated that with the creation of the Office of Behavioral Health, there will be a positive impact on service delivery, and the basic care that individuals receive will be improved.

Statewide planning and development towards a comprehensive, community-based system of care is guided through the efforts of the State Mental Health Planning Council originally established under PL 99-660 guidelines with full consumer/ family representation from throughout the State. The Planning Council is responsible for Block Grant planning, together with OMH staff dedicated to this function. The membership of the Planning Council includes 40 members who are primary consumers, family members, parents of children with emotional/ behavioral disorders, advocates, Regional Advisory Council chairs, and human service agency (LGE) representatives. The council is geographically representative of the state. Included within the Council governance is the Programs and Services Committee that addresses matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state. The OMH consumer survey process, C'est Bon, and the C/Y family survey process, La Fete, were developed by and are monitored by this committee of the Council. The Planning Council and consumers have been very active in service system performance evaluation.

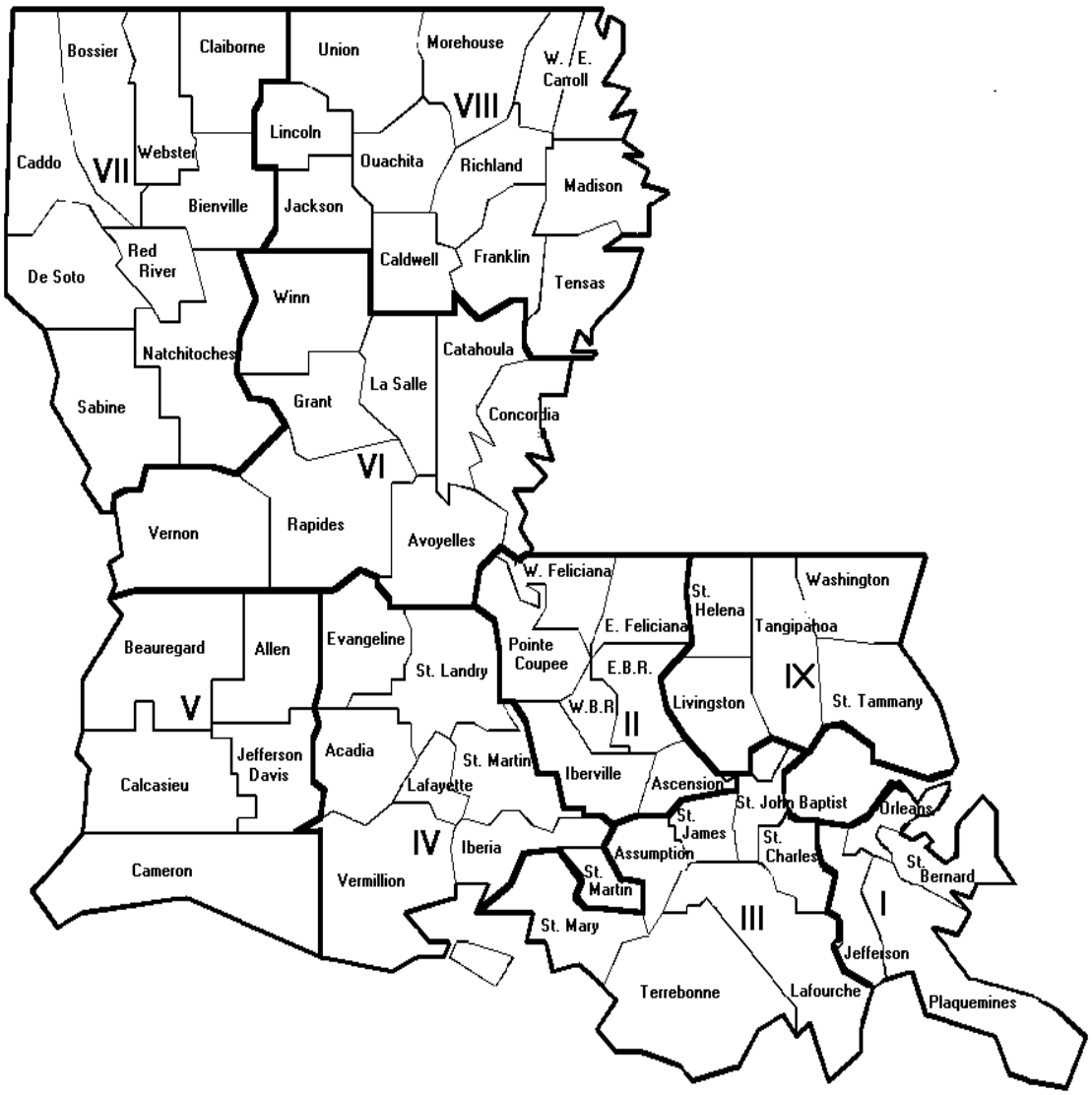
Readers are referred to the State Maps and Organizational Charts, and tables that are provided in this section.



OMH Regions
Regions 4 through 8*

DHH – Local Governing Entities (LGEs)
Metropolitan Human Services District (MHSD)
Capital Area Human Services District (CAHSD)
Florida Parishes Human Services Authority (FPHSA)
Jefferson Parish Human Services Authority (JPHSA)

*Region 3 transitioning to
South Central Louisiana Human Services Authority (7/1/2009)



OMH REGIONS & LOCAL GOVERNING ENTITIES, INCLUDING PARISHES SERVED

Region I Metropolitan Human Services District (MHSD)
Region II: Capital Area Human Services District (CAHSD)
Region III: *transitioning to* South Central Louisiana Human Services Authority
Region IV
Region V
Region VI
Region VII
Region VIII: *(will become Northeast Delta Human Services Authority)*
Region IX: Florida Parishes Human Services Authority (FPHSA)
Region X Jefferson Parish Human Services Authority (JPHSA)

(See accompanying text for a full description of *Region and Local Governing Entities*)

This section includes a detailed listing of all community mental health facilities and state psychiatric hospitals statewide as of August, 2009, including both the OMH Regional and Local Governing Entity (LGE) facilities. In summary:

- The community mental health programs include:
    - 43 Community Mental Health Clinics (CMHCs), that are full service, full time, licensed, fixed-site mental health programs. The regional CMHC is the hub of service provision and administration and fiscal services of the region
    - 27 Outreach locations that are satellites providing services off-site, part-time, under the license of a clinic, and through the providers of that program

    Note: This listing does not include the additional community services that are provided by each region under professional and social services contracts

- There are three OMH state psychiatric hospitals providing acute, intermediate, and specialized inpatient care; including one forensic division. *During the summer of 2009, the services previously provided at a fourth hospital, New Orleans Adolescent Hospital (NOAH) were transferred under the umbrella of Southeast Louisiana Hospital (SELH).*

    Note: Acute psychiatric inpatient units are short-term (generally less than 14-day) programs utilized to stabilize persons in mental health persons showing emergency need so as to return them back to community functioning as soon as possible. State Psychiatric hospitals include an acute unit but generally provide more intermediate to long-term length of care beyond the acute phase of a person's illness

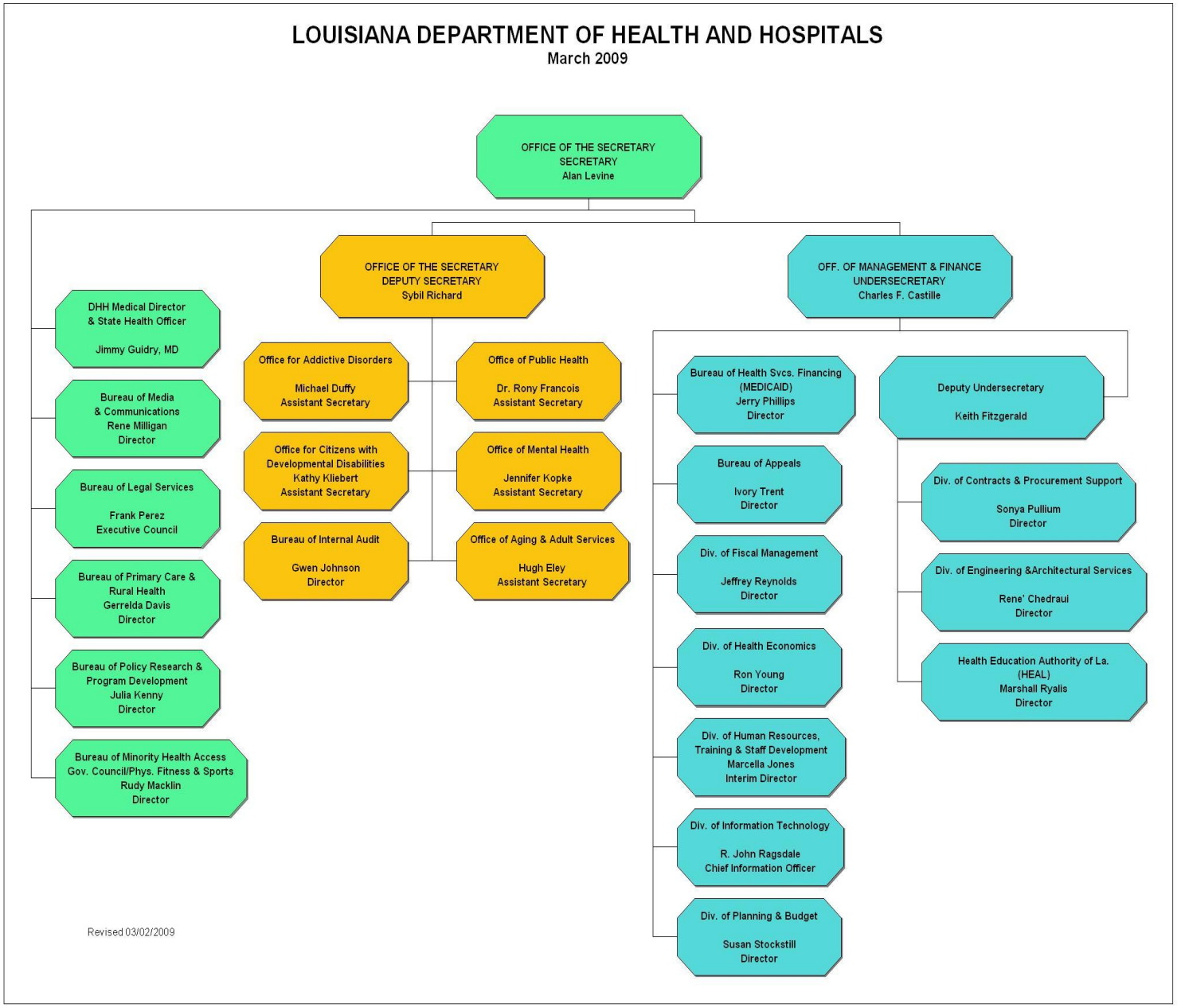
MENTAL HEALTH CLINICS AND OUTREACH LOCATIONS (7/2009)

MHSD (Region 1)	Location / Status
Plaquemines Behavioral Health Clinic	Belle Chase
Chartres-Pontchartrain Behavioral Health Clinic	New Orleans
St. Bernard Behavioral Health Clinic	St. Bernard
Central City Behavioral Health Clinic	New Orleans
New Orleans East Behavioral Health Clinic	New Orleans East
Algiers-Fischer Outreach	Algiers
Desire Florida Mental Health Clinic	***Closed*** *due to hurricane*
St. Bernard Mental Health Clinic	***Closed*** *due to hurricane*
CAHSD (Region 2)	
Baton Rouge Mental Health Clinic	Baton Rouge
Gonzales Mental Health Clinic	Gonzales
Margaret Dumas Mental Health Clinic	Baton Rouge
Clinton Outreach	Clinton
Donaldsonville Outreach	Donaldsonville
New Roads Outreach	New Roads
Plaquemine Outreach	Plaquemine
Port Allen Outreach	Port Allen
St. Francisville Outreach	St. Francisville
REGION 3	
Terrebonne Mental Health Clinic	Houma
Lafourche Mental Health Clinic	Raceland
South Lafourche Mental Health Clinic	Galliano
River Parishes Mental Health Clinic	LaPlace
St. Mary Mental Health Clinic	Morgan City
Assumption Mental Health Clinic	Labadieville
Lutcher Outreach	Lutcher
Vacherie Outreach	Vacherie
REGION 4	
Dr. Joseph Henry Tyler MH Clinic	Lafayette
New Iberia Mental Health Clinic	New Iberia
Crowley Mental Health Clinic	Crowley
Ville Platte Mental Health Clinic	Ville Platte
Opelousas Outreach Clinic	Opelousas
Abbeville Outreach	Abbeville
St. Martinville Outreach	St. Martinville
Eunice Outreach	Eunice
Kaplan Outreach	Kaplan
Church Point Outreach	Church Point
Mamou Outreach	Mamou
REGION 5	
Lake Charles Mental Health Clinic	Lake Charles
Allen Mental Health Clinic	Oberlin
Beauregard Mental Health Clinic	DeRidder

REGION 6	
Mental Health Clinic of Central LA.	Pineville
Leesville Mental Health Clinic	Leesville
Avoyelles Mental Health Clinic	Marksville
Jonesville Outreach Clinic	Jonesville
Bunkie Outreach	Bunkie
Winnfield Mental Health Outreach	Winnfield
Simmsport Outreach	Simmesport
REGION 7	
Shreveport Mental Health Clinic	Shreveport
Natchitoches Mental Health Clinic	Natchitoches
Minden Mental Health Clinic	Minden
Mansfield Mental Health Clinic	Mansfield
Many Mental Health Clinic	Many
Red River Mental Health Clinic	Coushatta
Arcadia Outreach	Arcadia
Logansport Outreach	Logansport
REGION 8	
Monroe Mental Health Clinic	Monroe
Ruston Mental Health Clinic	Ruston
Jonesboro Mental Health Clinic	Jonesboro
Richland Mental Health Clinic	Rayville
Tallulah Mental Health Clinic	Tallulah
Bastrop Mental Health Clinic	Bastrop
Columbia Outreach (& Winnsboro Clinic- merged)	Columbia
Farmerville Outreach	Farmerville
Delhi Outreach	Delhi
Lake Providence Outreach	Lake Providence
Oak Grove Outreach	Oak Grove
St. Joseph Outreach	St. Joseph
FPHSA	
Lurline Smith Mental Health Clinic	Mandeville
Bogalusa Mental Health Clinic	Bogalusa
Rosenblum Mental Health Clinic	Hammond
Slidell Mental Health Outreach	Slidell
JPHSA	
East Jefferson Mental Health Clinic	Metairie
West Jefferson Mental Health Clinic	Marrerro

HOSPITALS

Central Louisiana State Hospital (CLSH)		Pineville
Eastern Louisiana Mental Health System (ELMHS)	**Greenwell Springs Division**	Greenwell Springs
	Forensic Division	Jackson
	East Division	Jackson
New Orleans Adolescent Hospital (NOAH)*transitioning to SELH		New Orleans
Southeast Louisiana Hospital (SELH)		Mandeville


LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
March 2009
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SECRETARY
Alan Levine
OFFICE OF THE SECRETARY
DEPUTY SECRETARY
Sybil Richard
OFF. OF MANAGEMENT & FINANCE
UNDERSECRETARY
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Bureau of Media
& Communications
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Frank Perez
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Rural Health
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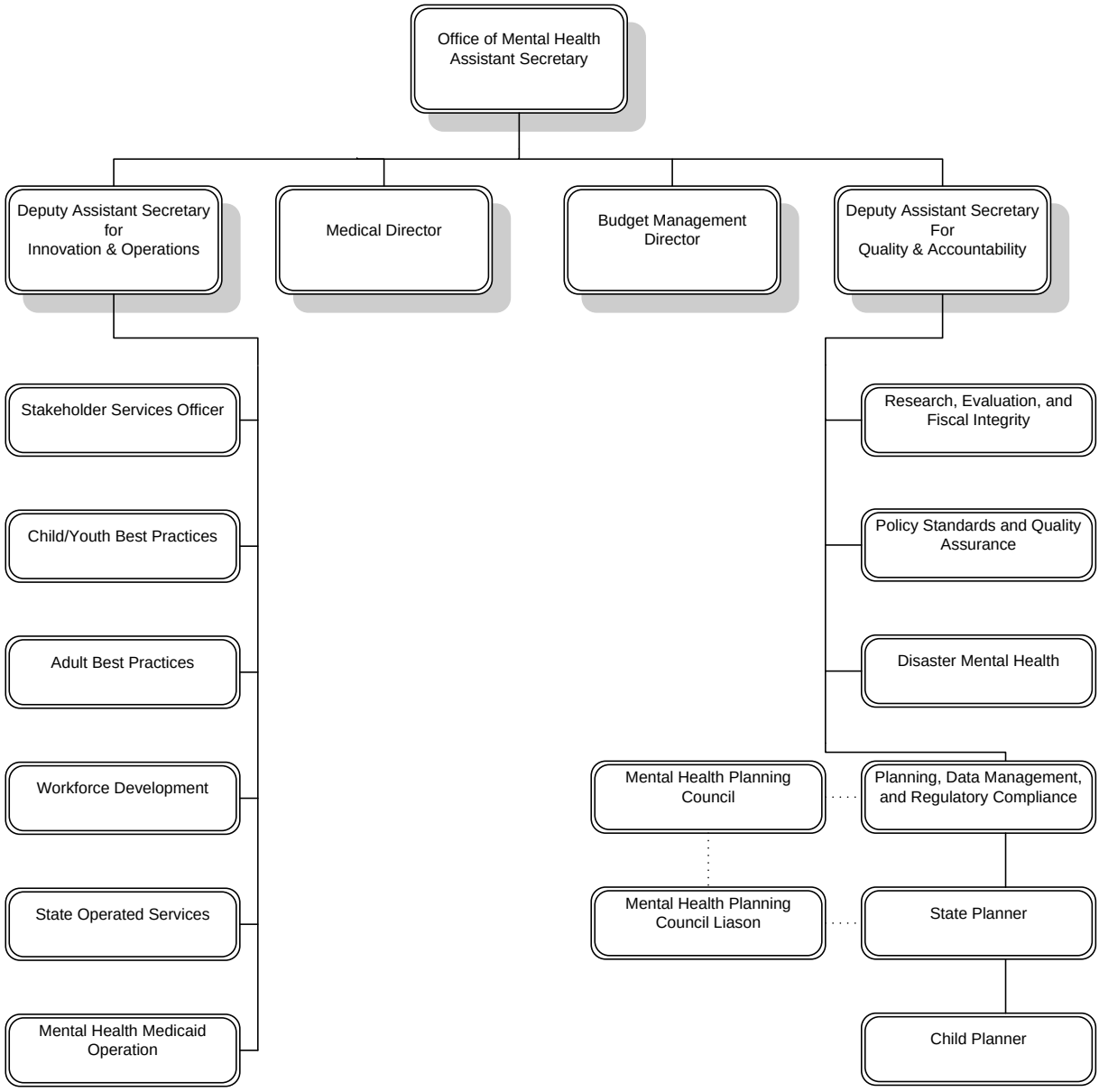
Sonya Pullium
Director
Div. of Engineering &Architectural Services
Rene' Chedraui
Director
Health Education Authority of La.
(HEAL)
Marshall Ryalis
Director
Revised 03/02/2009

Office of Mental Health

Organizational Chart

July 2008 *(Provisional)*



NEW DEVELOPMENTS AND ISSUES THAT WILL AFFECT MENTAL HEALTH DELIVERY IN FY 09-10

There are several new developments and issues which may affect mental health delivery this year and for years to come. Some notable items include Louisiana's adoption of Multi-Systemic Therapy (MST) under the rehabilitation option, the development of the Medicaid Behavioral Health Section within the Medical Vendor Administration program, and the new formation of the Office of Behavioral Health within the Department of Health and Hospitals.

The State of Louisiana continues to recover from hurricanes that have changed the way that mental healthcare is delivered in the state. The state was obviously challenged by Hurricanes Katrina and Rita in 2005; and then again in September of 2008 when Hurricane Gustav hit the metropolitan Baton Rouge area. Gustav's destructive path included the heart of the government for the entire state, and notably, the Department of Health and Hospitals, Office of Mental Health administrative headquarters. Following on the heels of Gustav, Hurricane Ike impacted the area of the state that had been previously affected by Hurricane Rita.

Hurricane preparedness, response and recovery have become a part of every healthcare provider's job description, and employees have learned that every disaster is different, often requiring new learning and flexibility. As an example, employees of OMH are now on standby alert status should a storm threaten the coast, and all employees are expected to be active during a crisis. All Louisiana families are encouraged to *"Get a game plan"* (http://getagameplan.org/) in order to be prepared for a hurricane, should one strike.

The newly legislated merger of the Office of Mental Health with the Office for Addictive Disorders to become the Office of Behavioral Health (OBH) is anticipated to be a major focus over the next year. The merger was mandated in the 2009 Regular Session of the Louisiana Legislature that adjourned June 25, 2009, and is further described in the *Overview of the Mental Health System* in Section I. Although not without controversy, the move is anticipated to result in more seamless and coordinated care, while eliminating redundancies at the administrative level.

Funding to healthcare in the state budget was significantly reduced in the just ended legislative session. Since education and healthcare budgets are areas that are not constitutionally protected in the state constitution, they are often the areas that are hardest hit when revenue is down. In a state that is known for high levels of poverty, high rates of chronic illness, and high percentage of school drop-out rates, these cuts are significant.

Multi-systemic Therapy was approved under state plan and allowed reimbursement beginning July 1, 2008. Since November of 2008, 11 providers and over 20 new therapists have enrolled in the MST program. This should have a positive effect, limiting the number of juveniles who might otherwise require out of home placement. Medicaid has developed and maintained close collaborative relationships with both the Office of Community Services and the Office of Juvenile

Justice, and anticipates additional requests and opportunities to develop evidence based mental health services for youth within Medicaid. These positive collaborations will likely also result in increased utilization of available Medicaid behavioral health services by recipients assisted by those agencies.

The Louisiana Medicaid Behavioral Health Section was launched within Medicaid's Medical Vendor Administrative section on July 1st 2009, and will be responsible for the oversight, management and administration of all Medicaid-funded behavioral health services. It is expected that this new section will work collaboratively with other health care service agencies within the state to improve access to medically necessary behavioral health services. Under this new section, it is likely that Louisiana will see a continued migration toward managed behavioral health care and greater utilization tracking, review and utilization management of all services. This new section will work toward achieving goals established by the Office of Mental Health in its role as the state's mental health authority. Such goals include increasing access to services, decreasing fragmentation of services, increasing evidence based services, increasing quality standards, and decreasing reliance on utilization of jails, emergency rooms, and inpatient psychiatric hospitals, while increasing access to more community-based mental health services. It is also expected that this section will work toward integrating substance abuse services into the system of care.

The transition of both the Office of Mental Health and the Office for Addictive Disorders into one Office of Behavioral Health should also work toward similar goals of increasing access to evidence based services for those adults with severe and persistent mental health issues, youth with emotional/behavioral disorders and those affected by substance abuse issues. Similarly, Louisiana's movement toward the medical home model should help with integration of primary medical and behavioral health services, improving the system of care and coordination of services.

Louisiana was alerted in March of 2009 that the Block Grant funds would be reduced by 11.7% for the 2009 (and 2010) fiscal year. In an attempt to understand the reduction, it is believed that it is a result of several converging elements that occurred after the hurricanes in 2005. The devastation in the Gulf Coast area caused an infrastructure and housing shortage which lead to a ***temporary*** post-hurricane boom in construction jobs as well as a ***temporary*** influx of money from government sources and industry. In addition, there was a ***temporary*** decrease in the numbers of people living in Louisiana. The reality is that these changes were indeed ***temporary***, and the resultant cut has meant a reduction in needed services that had been previously supported by Block Grant money.

Similarly, Louisiana may also face significant budget cuts in the Medicaid allowance in the 2011 fiscal year, due to the formula used to calculate Medicaid funding. The federal Medicaid reimbursement rate is calculated by the independent Bureau of Economic Analysis, using a formula that is based on total personal income in the state. Louisiana faces a loss of hundreds of millions of dollars per year, based on this calculation. The reason for this dilemma is that the formula is using income that is artificially inflated by the insurance payments and federal aid in the wake of the 2005 hurricanes. The Louisiana delegation, including the Secretary of the Department of Health and Hospitals has been to Washington to plead the case for relief. The administration is hopeful that Congress listens, but the hurricanes have receded from the national consciousness; coined as "Katrina fatigue" in Louisiana. Governor Jindal is quoted on July 22, 2009 in the Baton Rouge newspaper, the *Advocate*, as saying "The people of Louisiana have been devastated by four major storms in just over three years and they're fighting to get back on their feet, and should not be

victimized again by their own government." In 2011, the federal stimulus package also ends, and Louisiana is indeed facing some lean economic times.

Fund Development

The Fund Development division under the auspices of the Office of Mental Health facilitates and supports technical assistance in the pursuit of grant funding that further the agency's mission. Grant funds received from governmental agencies have provided the agency, its staff and the community with additional program opportunities not funded through the legislative appropriation for Louisiana's Office of Mental Health. The following overview of the 2008-2009 fiscal year provides information about existing continuation awards.

Continuation Awards

- Louisiana Partnership for Youth Suicide Prevention – The Office of Mental Health was awarded funds totaling $1,200,000 for a three-year project period. This project period has been extended to a fourth year and is scheduled to end in 2010. Since 2007, more than 4,139 youth and families have received direct programmatic services through a system of gatekeeper training, teen screenings, state advisory board meetings, area coalition meetings, safe talk, youth health summits, and statewide awareness activities with the goal of reducing the incidence of suicide in Louisiana.
- LA Spirit and Recovery, a series of FEMA/SAMHSA service grants through the Federal Emergency Management Agency and administered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health is in its final phases. The Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana which focuses on addressing post hurricane disaster mental health needs and other long-term disaster recovery initiatives, in coordination with other state and local resources. As of June 2009, Louisiana has been awarded $19,537,929 for the Immediate Services Program and another $70,847,621 for the Regular Services Program for Hurricanes Katrina, Rita (2005), and Gustav (2008). The Louisiana Spirit and Recovery Regular Services Program for Katrina and Rita related services ended December 31, 2008. Crisis Counseling Program services for Hurricane Gustav began in September 2009 and is projected to continue until December 2009. More detail about this project can be found in Section III, Criterion 1.
- The Lafayette Jail Diversion Project – Target Capacity Expansion Grant is a $1.2 million three year grant funded by the Substance Abuse and Mental Health Services Administration. This project has been extended a fourth year and is scheduled to end in 2009. The grant funds implementation of a post-booking jail diversion program with condition of release, utilizing the Lafayette Sheriff's Department as the central diversion point for project participants.
- Alternative to Restraint and Seclusion – In 2004, the Office of Mental Health was awarded funding for a 3 year project period. This funding was extended a fourth year and ended January 31, 2009. During this pilot project period, improvement efforts were successful towards reducing the overall incidence of restraint and seclusion in two OMH inpatient adolescent psychiatric hospitals (Southeast Louisiana Hospital in Mandeville and Central Louisiana State Hospital in Pineville). Substantial progress has been made in the development of core strategies and intervention tools, cultural changes, and revisions of policies, procedures, and philosophy. The greatest improvement has been in restraint

reduction with an approximate 75% of the goals achieved. The total funding for the project period was $610,000.

- Louisiana Youth Enhanced Services for Mental Health (LA YES) is a continuing "cooperative agreement" that is now in its seventh year of funding from SAMHSA totaling $9.5 million. This initiative provides services in five Southeast Louisiana Parishes (in the New Orleans area). Sustainability efforts continue with strategies to collaborate with child-serving partner agencies including the LGEs.

SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
LEGISLATIVE INITIATIVES & CHANGES
LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

LEGISLATIVE INITIATIVES AND CHANGES

Implementation of several legislative initiatives from last year's legislative session, the 2008 Regular Session of the Louisiana Legislature included:

- ACT 153: Completed. Allows for the mechanism of performing emergency certificates via telemedicine utilizing video conferencing technology. OMH policy was developed, reviewed, and posted.
- ACT 373: Completed. Provides relative to the governance, functions, and responsibilities of the human services districts. Readiness assessment developed, reviewed and approved. Initial implementation with Region 3/ South Central Louisiana Human Services Authority was successful. DHH prepared to provide technical assistance for LGEs in accordance with this Act.
- HCR 155: Completed. Urges and requests DHH to study the development and implementation of civil commitment procedures for the treatment of sexually violent predators and child sexual predators. A committee was constituted, literature was reviewed, and expert technical assistance was provided. A report with recommendations was submitted to the legislature in March, 2009.
- HCR 184: Completed. Creates the Mental Health Care Improvement Task Force to study the ongoing mental health care crisis in Louisiana and make recommendations on how to efficiently implement and find funding sources for key recommendations in LA's Plan for Access to Mental Health Care. The task force presented recommendations and endorsements to the legislature in March 2009.
- ACT 447: Completed. Development of Licensing Standards (DHH Health Standards) for crisis receiving centers. Joint meetings were held between OMH and DHH Health Standards, with guidance from a national consultant. Each Region/ LGE has created and will continue to develop local Crisis Response Systems designed by a local collaborative with broad service stakeholder representation as outlined in the legislation.
- ACT 407: Completed. Provides for assistive outpatient placement. Assistive Outpatient Treatment Policy and Procedure developed, reviewed, and posted. Training was provided, and implementation continues.

The 2009 Regular Session of the Louisiana Legislature was a *fiscal only* session meant to focus primarily on fiscal issues; however, each legislator was allowed to file up to 5 non-fiscal bills. During the session that ended June 27, 2009, there were 1,255 bills filed.

Legislation within the fiscal budget bill allows OMH to close one of its state hospitals, New Orleans Adolescent Hospital (NOAH), and transfer the child/adolescent and adult acute beds to Southeast Louisiana Hospital (SELH) and with the savings in operational costs, will allow for the opening of two new community mental health clinics in locations convenient to consumers in the New Orleans area. In addition, bills that passed the 2009 Louisiana Legislature that may impact persons with mental illness are as follows:

- ACT 272: Authorizes certain persons to offer *testimony by simultaneous audiovisual transmission* if such technology is available in the courtroom, during any criminal proceeding, juvenile or family court proceeding which is of a criminal nature, and any civil forfeiture proceeding arising from alleged criminal activity.
- ACT 205: Provides for the *monitoring and supervision of sex offenders* by extending supervised release of certain sex offenders for life, and amends procedures governing the supervision of sexually violent predators and child sexual predators.
- ACT 384: Dissolves the office of mental health and the office for addictive disorders, and combines the functions of the two offices to *create one office of behavioral health* within the Dept. of Health and Hospitals.
- ACT 230: Subsequent to a finding that a child is incompetent to proceed pursuant to a felony charge, upon a showing of good cause that a child presents a danger of flight, the court may authorize the Department of Health and Hospitals to use appropriate *restraints on a child during transport*, until further order of the court. Use of restraints pursuant to the provisions of this Section shall comply with the policy of the Department of Health and Hospitals on seclusion and restraints.
- ACT 251: The *Medical Psychology Practice Act* transfers the regulation of medical psychologists from the State Board of Examiners of Psychologists to the Louisiana State Board of Medical Examiners and provides for requirements for and rights acquired by licensure, prescribing drugs, and other regulations for such profession.
- ACT 253: Provides for the *conversion of Jetson Center for Youth* to a regional treatment facility.
- HCR 238: The Legislature of Louisiana does hereby express its support for DHH, and various partners for participating in the *Primary Care Access and Stabilization Grant* (PCASG), which expires September 30, 2010, for their substantial progress in meeting essential primary medical and behavioral health care needs in Region One (Jefferson, Orleans, St. Bernard, and Plaquemines parishes).
- HR 88 & SR 128: Provides for study of the continuing *effects of Hurricanes Katrina and Rita on the mental health of women* living in Louisiana.

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part C
STATE PLAN
Section II

Adult & Child/ Youth

IDENTIFICATION & ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS NEEDS & PRIORITIES

SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM'S STRENGTHS, NEEDS, & PRIORITIES

SERVICE SYSTEM'S STRENGTHS & WEAKNESSES

LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

The *President's New Freedom Commission Report* found that the mental health care system needs to be fundamentally transformed to become recovery oriented, to integrate programs that are fragmented across levels of government and different agencies, and to replace unnecessary institutional care with efficient, effective community services.

The strength of the Louisiana mental health system lies in the dedication and commitment of the workforce, as shown most dramatically by the hurricane response after the hurricanes of 2005, and again in 2008. While the response to four major hurricanes occurring in a little over three years has preoccupied much of the workforce, slow and steady progress towards meeting goals and improving the delivery of mental health care is being made in a systematic way. That advancements are being made is shown in the progress made in the Cornerstone project discussed below; and the move towards implementing a greater number of evidence based practices in the clinics.

Nationwide, it is agreed that healthcare is in need of reform. Mental health in particular has been burdened by a lack of adequate infrastructure, an insufficient workforce, and declining funding. Louisiana historically has had a fragmented mental health system and access to care has been inadequate. The downturn in the economy has created further problems with individuals losing health care benefits; whether because of industry cutbacks or by loss of employment.

Extensive programmatic review of Louisiana's mental health systems and services has been undertaken during previous administrations. The ensuing reports have identified inadequacies and have provided specific recommendations for improvement. The most recent report, *A Roadmap for Change* was published in June, 2006, and continues to provide a useful schema to follow in examining transformation efforts.

A Roadmap for Change:
Bringing the Hope of Recovery to Louisianians with Mental Health Conditions

Prior to the hurricanes, the Louisiana Department of Health and Hospitals (DHH) commissioned a programmatic systems and services review of mental health care in Louisiana, resulting in a document that was published in June, 2006, and did include evaluation of the system post-Katrina and Rita. The final document, *A Roadmap for Change: Bringing the Hope of Recovery to Louisianians with Mental Health Conditions* was the result of this review, and included recommendations for transformation. A synopsis of the major findings highlighted fifteen focus areas. While the study is a thorough critique of the system, it is also aspirational. The administration continues to utilize the findings of the report in studying and setting priorities, and evaluating recommendations made therein. A summary of the *Roadmap* findings is found in a Table in this section.

It has been previously acknowledged that in order for meaningful progress to occur, reform must take a broad coordinated approach involving federal, state, and local governments, public/ private partnerships and citizens coming together. The recognition by the public that mental illness is a real and treatable health disorder continues to be a challenge.

As stated in the final *President's New Freedom Commission Report*, successful transformation of the mental health service delivery system to promote recovery rests on two key principles:

1) Services & treatments must be consumer- and family- driven; geared to give consumers real and meaningful choices about treatment options and providers, and not oriented to the requirements of bureaucracies.

2) Care must focus on increasing individuals' ability to cope successfully with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

SYNOPSIS OF MAJOR FINDINGS BASED ON *ROADMAP* SYSTEMS AND SERVICES REVIEW*

	FOCUS AREA	FINDING
1.	Vision & Mission	Louisiana has no widely understood or accepted and shared vision to guide the delivery of mental health services to adults, children, and families.
2.	Leadership	Key leadership positions in DHH have experienced turnovers, and some are filled by persons in "acting" roles.
3	Service Delivery Structures; State (DHH) / District Governing Relationship	While progress has been made to provide health care services under a District/ Authority model, much of the State's structures providing public mental health, substance abuse and developmental disability services currently operate under a variety of differing geographic and process models.
4	Organization and Role of Office of Mental Health	Louisiana's increasing move toward a district model for delivering services in the community will necessitate the role and function of the OMH to change from that of principally a service provider to one where the office is the coordinator of a more distributive and integrative model of service delivery.
5	Financing & Budget	Louisiana has an inadequate financing strategy to ensure access to appropriate mental health services. Louisiana lacks a comprehensive framework to use for understanding and assessing the adequacy of its financial investment in mental health services. Louisiana has not taken sufficient steps to secure existing financial resources nor to fully seize opportunities to increase resources for mental health services.
6	Evidence-based Practices	Louisiana currently makes very limited use of evidence-based and best practices and in only isolated areas of the State, never seeming to be brought to a statewide scale. Where these practices do exist, soon after Federal or other grant dollars that helped to initiate them end, they can no longer be afforded or otherwise supported, and are abandoned.
7	Acute Care/ Crisis Response Network	Louisiana lacks alternatives to traditional crisis services thus creating an even greater shortage of the State's acute, inpatient bed capacity.
8	Suicide Prevention and Response	Louisiana ranks 38th in the nation in terms of suicide rates. There is much uncertainty and concern across the State as to whether the suicide rate has increased in the aftermath of the hurricanes. The data needed to draw these conclusions is incomplete.
9	Cultural Competence and Eliminating Disparities	The capacity of Louisiana's State Departments, agencies and providers are challenged in meeting the mental health care needs of the State's highly diverse, heterogeneous populations.
10	Workforce Development	As is the situation in every state, Louisiana is facing a serious shortage of professionals and para-professionals trained in providing evidence-based and best practice mental health services for children, adults, and older adults.
11	Children, Youth, and Families	In Louisiana, only 7-14% of children with mental health disorders are receiving services and only 13% of the Office of Mental Health's budget is spent on children's services.
12	Primary Care Integration	The primary healthcare needs of Louisiana communities are well understood, however, DHH lacks a process to assess behavioral health needs at the community level, thus missing opportunities for significant integration and collaboration.
13	Homelessness and Housing	Serious mental illness and substance abuse are the two most significant factors contributing to homelessness in Louisiana. The State faces a serious lack of affordable housing, especially for people with disabilities, a situation exacerbated by the impact of Hurricanes Katrina and Rita.
14	Employment	Adults and youth with mental disorders are drastically unemployed and underemployed in Louisiana. Effective policy and service strategies have recently been clearly identified and, if implemented, could significantly improve rates of employment for mental health consumers.
15	Criminal Justice	Mental health services for those individuals and families who come before the State's criminal, family, and juvenile court system are woefully inadequate.

*taken from *A Roadmap for change: Bringing the Hope of Recovery to Louisianans with Mental Health Conditions: Recommendations for Transformation Based on Findings from a Review of Mental Health Systems and Services. Prepared for: Louisiana Department of Health and Hospitals. Prepared by: Behavioral Health Policy Collaborative, Alexandria, VA; Technical Assistance Collaborative, Boston, MA. June, 2006.*

Louisiana's Plan for Access to Mental Health Care

The *President's New Freedom Commission Report* found that the mental health care system needs to be fundamentally transformed to become recovery oriented, to integrate programs that are fragmented across levels of government and different agencies, and to replace unnecessary institutional care with efficient, effective community services. In response to these concerns, previous Governor Kathleen Blanco issued an Executive Order (KBB 05-16) calling for development of *"Louisiana's Plan for Access to Mental Health Care."* To begin to address the deficiencies noted by the *New Freedom Commission Report* and carry out the Executive Order, a series of stakeholder meetings were held throughout the state to gain knowledge, input, and recommendations on how we can all work together to improve access to mental health care. Workgroups were then established with representation from thirteen State level Departments and various other stakeholders, including advocacy groups. The thirteen agencies mandated by the Executive Order are listed below.

- Department of Health and Hospitals (lead agency)
- Department of Public Safety & Corrections
- Department of Social Services
- Department of Transportation & Development
- Department of Education
- Department of Labor
- Department of Insurance
- Office of Youth Services
- Department of Veterans Affairs
- Louisiana Housing Finance Agency
- Governor's Office of Elderly Affairs
- Governor's Office of Disability Affairs
- Louisiana State University Health Sciences Center

The charge of this group was to develop a comprehensive and effective plan for the transformation of Louisiana's mental health care system, including recommended administrative and legislative actions that may be reasonably achieved by 2010 with resources available to the state. The work of this group identified six Goals, each having Strategies, Objectives, and Measures, along with timelines for completion of each. The Goals of Louisiana's Mental Health Plan are listed in the following Table:

LOUISIANA'S PLAN FOR ACCESS TO MENTAL HEALTH CARE	
Goal One:	Increase the use of evidence based, developmentally appropriate practices, for children, adults, and families to access needed mental health services.
Goal Two:	Establish an accessible continuum of crisis services and crisis avoidance and provide a realistic array of treatment services in both the private and public sector.
Goal Three:	Provide effective services for children, young adults and their families which are designed to meet their emotional, cognitive, developmental and physical needs, provided in environments to ensure success.
Goal Four:	Provide primary health care and behavioral health care at comprehensive access sites.
Goal Five:	Provide all individuals with behavioral health (mental health and/or addictive disorders) conditions with appropriate individualized supportive services to secure and maintain their education, employment and housing goals.
Goal Six:	Define, establish, and sustain the Leadership role of the Office of Mental Health in order to efficiently and effectively accomplish "Bringing the Hope of Recovery to Louisianians with Mental Health conditions" as delineated in the *"Roadmap for Change."*

The progress made by the Louisiana's Plan for Access to Mental Health Care workgroup is outlined below; taken from the *Report in Response to HCR 184 of the 2008 Regular Session, Mental Health Care Improvement Task Force; Submitted by the Department of Health and Hospitals, June 4, 2009.*

Goal One: **Increase the use of Evidence-Based, Developmentally appropriate practices for children, adults, and families to access needed mental health services.**

Strategy One: Identify list of Evidence based practices (EBPs) and establish priorities

- The workgroup recommended the following EBPs as the initial focus for statewide training and implementation: Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Assertive Community Treatment, Forensic Assertive Community Treatment, Multi-Systemic Therapy, Functional Family Therapy, Illness Management and Recovery, Family Psychoeducation, Medication Management Approaches in Psychiatry, Supported Employment, and Co-Occurring Disorders: Integrated Dual Disorders Treatment.

Strategy Two: Engage departments and provider leadership to establish consensus on the principles of using EBPs

- The collaboration workgroup was created consisting of leaders from multiple agencies.
- The collaborative recommended the regions and LGEs begin training on EBPs for implementation contingent upon workforce issues and funding availability.

Strategy Three: Support the use of evidence based practices through sustainable funding and other needed resources to support model implementation.

- DHH, Department of Social Services (DSS), and the Office of Juvenile Justice (OJJ) collaborated effectively with Medicaid to add one EBP – Multi-Systemic Therapy (MST) -- for Medicaid coverage.

- Primary Care Stabilization and Access Grant (PCSAG) funding provided training and start-up costs for MST services in the New Orleans area.
- Assertive Community Treatment (ACT) has been implemented in some OMH regions and the LGEs with a blended funding stream of SGF and Federal Block Grant dollars.
- The MacArthur Foundation provided funding for a Functional Family Therapy (FFT) program located in Region 6.
- Through the Governor's Executive Order BJ-2008-12, Forensic Assertive Community Treatment (FACT) has been implemented in greater New Orleans.
- Through the Governor's Executive Order BJ-2008-12, Assertive Community Treatment (ACT) has been implemented in Jefferson, Orleans, Plaquemines, and St. Bernard Parishes.
- The Technical Assistance Collaborative is providing technical assistance to OMH for opportunities to secure Medicaid reimbursement for ACT.
- The national outcome data on EBPs provides strong evidence in support of community-based EBP sustainability as evidenced by declines in hospitalizations and with increases in quality of life

Strategy Four: Implement and support the use of evidence-based practices through training and technical assistance.

- The workgroup recommended developing partnerships with universities and community colleges and other state agencies for cross training opportunities.
- The workgroup recommended the development of a collaborative cross- agency workforce development strategy.
- Implementation of the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams has been in accordance with training and consultation provided by the National Alliance for the Mentally Ill Technical Assistance Center and The Technical Assistance Collaborative.
- Implement a model plan of permanent housing and supports (PSH) for persons with severe and persistent mental illness and/or co-occurring disorders. This model of PSH has been initiated with consumers who are active clients within the ACT and FACT programs.
- Dialectical Behavioral Therapy (DBT) training is being provided by Behavioral Tech, LLC.
- Cognitive Behavioral Therapy (CBT) training is being provided by LSU Health Sciences Center's Department of Psychiatry in New Orleans, LA.
- Training opportunities to increase MST and FFT teams statewide will be on-going to maintain fidelity to the EBPs models.
- After completion of statewide training for competency and fidelity, EBPs will be implemented as resources allow.

Strategy Five: Design and implement quality assurance processes that measure the impact of programming, treatment, and/or services.

- Workgroup recommended utilizing cross-agency collaboration for data sharing and data analysis to design a quality assurance program to sustain fidelity to the EBP models and the impact to programming, treatment outcomes, and/or service outcomes.
- Workgroup recommended the implementation of a quality process for continuous performance accountability to continue to achieve established goals and new cost effective strategies.
- OMH is in the implementation phase of selecting and implementing an electronic health record.
- OMH is actively engaged in the training and implementation of a system of care initiative referred to as Cornerstone. Cornerstone is comprised of four parts: (1) Resiliency & Recovery; (2) Utilization Management; (3) Credentialing and Privileging; and (4) Performance Improvement.
- OMH is engaged in an accountability system titled Service Process Quality Management (SPQM). The system is designed to provide transparency and accountability within the state system of care.

Goal Two: **To establish an accessible continuum of crisis services and crisis avoidance and to provide a realistic array of treatment services in both the private and public sector.**

Strategy One: Standardize crisis avoidance and intervention.

- Legislative Act 447 – Crisis Response System Development enacted in Regular Session 2008 to provide for crisis receiving centers and systems.

Strategy Two: Standardize crisis assessment and referral process

- A Crisis Response System Collaborative statewide meeting was held with leadership from across agencies within regions and LGEs in January 2009 to address ACT 447 as a collaborative effort with all stakeholders invited to participate inclusive of OMH, OAD, OCDD, law enforcement, EMT, Emergency Room Physicians, etc.
- A Toolkit for Building a Local Collaborative was designed and distributed to stakeholders attending the Crisis Response System Collaborative meeting.
- The collaborative crisis system includes but is not limited to Screening & Assessment Tools, Mobile Crisis Team, Crisis Intervention Team, Case Management, Assertive Community Treatment, and Crisis Intervention Units.
- The Child and Adolescent Response Team (CART) is operational statewide to provide 24/7 multi-disciplinary, community-based intervention for children in crisis situations.
- DHH Health Standards is working with OMH/OAD and Medicaid in the development of certification standards for crisis receiving centers to be subsumed under several existing DHH licenses. This will allow for existing funding of current programs to be utilized for crisis receiving centers.

Strategy Three: Build a continuum of care at the local level.

- Local level meetings have been on-going in the regions and LGEs with a large number of public and private community participants (e.g., EMS, law enforcement, coroner's office, emergency departments, advocates, administrative, etc.) working together in a collaborative manner to design a continuum of care plan that best meets the needs of the communities. The underlying assumption is that crisis response is a community issue that involves multiple entities, both public and private. The regional/ local Crisis Response System plans are intended to take advantage of local NAMI/ law enforcement efforts to establish Crisis Intervention Teams (CIT) within local police units. CIT is a nationally recognized EBP. The local participants are tasked with: (1) identifying current resources used by public and private agencies to address behavioral health crises within their communities; (2) specifying strategies for building a comprehensive crisis response system on an incremental basis over the next three to five years; (3) identifying current funding streams within communities and redirecting these resources to address the desired crisis response continuum; (4) identifying the design and function of crisis receiving centers within this crisis response system utilizing the OMH conceptual framework for crisis receiving centers. The framework is based on the hub and spoke design of the three levels of crisis receiving centers; (5) projecting a budget for each year of incremental implementation, first reinvesting existing resources and then making recommendations to DHH for additional funding, with specific budgets for crisis receiving centers; (6) review the availability of Mental Health Emergency Room Extensions (MHERE) in local areas and determine what enhancements are needed to convert MHEREs to crisis receiving centers.

Strategy Four: Develop and implement a workforce development strategy.

- Credentialing of staff to deliver EBPs is primarily dictated by the EBP model to meet fidelity standards. Collaboration is ongoing to discuss current workforce capacity and ongoing workforce development issues

through training opportunities with current staffing patterns across the state and for future recruitment of staff for these specialized evidenced based programs.

Strategy Five: Develop a system for sharing information

- Each Region and LGE has actively developed a well organized system for information sharint as a result of the extensive work efforts of stakeholders.

Goal Three: **Provide Effective Services for Children, Young Adults and Their Families designed to meet their emotional, cognitive, developmental and physical needs provided in Environments to ensure success.**

Strategy One: Support and implement effective community-based programs across the state.

- EBPs targeted to children, young adults and families are being implemented across areas of the state based upon funding availability and qualified staff.

Strategy Two: Develop and implement individual and family supports that will enhance quality of life.

- Behavioral health supports offered by NAMI Louisiana, MHAL, LA Federation of Families, and Meaningful Minds of Louisiana are integral to the continued efforts to provide quality of life opportunities to behavioral health clients. Examples of programs these organizations offer include NAMI Share, Community Outreach and Education, and leadership trainings.
- The LA Health First initiative will provide a model for the state to link primary and behavioral health care in a common location thus enhancing early intervention programs and expanding quality of life provisions.
- A grant from the Bristol Myers Foundation targeting pre- and post-natal women allows the Office of Public Health, in conjunction with OMH, to teach physicians how to use the SBIRT screening tool to identify those women at risk for depression, substance abuse and domestic violence.
- The Early Childhood Supports and Services (ECSS) program serves children ages 0-6 years and their families; providing parent training and referral to appropriate resources for high-risk children who may develop behavioral/emotional problems related to poverty and other environmental and genetic conditions. Emotional, social, physical, and cognitive development of young children is highlighted in this program.

Strategy Three: Engage the local community, stakeholders, and citizens in planning, resource development and advocacy.

- A strong collaborative effort exists for advocacy and is being sustained by public and private advocates and stakeholders with a commitment to provide early prevention and treatment for children, adults and families.
- Families Helping Families, LA Federation of Families for Children's Mental Health, and NAMI demonstrate significant support of community- based, best-practice planning and continued efforts in resource development.
- Interagency Service Coordination provides service and resource development for youth who are unable to get their needs met through one or two single agencies.
- With the Neighborhood Place initiative by Act No. 775 of the 2008 Regular Legislative Session, Louisiana is following Kentucky's model and creating multi-service centers in high poverty areas as one means of providing the full range of social services in a coordinated and seamless manner. The Departments of Social Services, Health and Hospitals, Workforce Development and Juvenile Justice are working together to establish three pilot centers – two in northern Louisiana and one in Orleans Parish. State and local level representatives are working to develop partnerships that include the local service providers.

Strategy Four: Allocate funding to support a continuation an/ or increase in effective services to all children, youth, adults and their families.

- Comingling of interagency funding, as well as blended funding to include grant opportunities and collaboration among agencies, is a strong component of statewide support in continuing and increasing effective services to this identified population. Collaborative efforts are ongoing with Medicaid in seeking to secure Medicaid funding for EBPs.

Strategy Five: Increase accessibility of behavioral health services.

- Access issues continue to be a challenge; however, progress is being made by collaboration among agencies. A significant challenge to the current behavioral health system of care remains workforce development issues, inclusive of psychiatrists, medical psychologists, psychologists, nurse practitioners, licensed social workers, licensed professional counselors, RNs, etc. to allow for timely access to the system of care for early intervention.
- Accessibility of behavioral health crisis services is available to all children and their families in the state for crisis intervention up to seven days to stabilize the crisis, refer to the appropriate community resources, and teach the families how to handle their own crises through the Child and Adolescent Response Team (CART).

Goal Four: **Provide primary health care and behavioral health care at comprehensive access sites.**

Strategy One: Study feasibility of implementing comprehensive access sites in communities.

- The Health Care Reform Act of 2007 directed DHH to develop and pilot a new system of care that will increase access, improve quality and provide sustainability in medical care for the Medicaid and uninsured population. The system of care is known as "Louisiana Health First."

Strategy Two: Identify successful models of primary care and behavioral health integration.

- The Louisiana Health First Technical Advisory Council consisting of an integrated system of public and private providers willing to participate in the system was convened.
- A Behavioral Health Ad-Hoc Workgroup was formed to address many issues inclusive of the task to research and evaluate successful models of behavioral health integration.
- The *ad-hoc* committee continues to meet to evaluate successful models from other states. Meetings are on-going and the work of the group is progressing.

Strategy Three: Develop implementation plan for introducing model for primary care and behavioral health integration into current programs and services in communities.

- The *ad-hoc* Workgroup (i.e., OMH, DHH Research and Development, Bureau of Health Services Financing, OAD, and Office of the Secretary) is working to develop implementation plans by identifying child/youth and adult behavioral health services based on best practice for the Louisiana Health First initiative.
- Funding issues and sources are being identified.
- A "cross-walk" is being developed with current service definitions and provider credentialing.

Strategy Four: Research and provide sustainable funding and other needed resources to support model implementation.

- The Louisiana Health First Medicaid Reform Initiative will be reimbursed based on successful managed care reimbursement principles set forth by the Bureau of Health Services Financing.
- The LA Health First Technical Advisory Council will continue to be updated by the Ad-Hoc committee regarding funding and workforce issues and resource requirements.

Strategy Five: Monitor program implementation.

- DHH will monitor LA Health First anticipating, at a minimum, (1) a 25 percent reduction in acute hospital admissions, (2) a 33 percent reduction in state hospital admissions; and (3) improvement in access to a system of community-based care through the implementation of evidence-based health care in a comprehensive primary care environment.

Goal Five: **Provide all individuals with behavioral health (mental health and/or addictive disorders) conditions with appropriate individualized supportive services to secure and maintain their education, employment, and housing goals.**

Strategy One: Increase educational opportunities and supports for individuals (both children and adults)

- Cross-agency collaboration among DSS (OCS, Louisiana Rehabilitation Services[LRS]), DHH (OMH/OAD), Department of Education, NAMI, and MHAL addressed current best practices occurring statewide, as well as future methods of collaborating for programs to serve children and adult students.
- The workgroup worked on methodology to ensure retention in both secondary and post-secondary educational settings.
- Educational supports are inclusive of PBS (Positive Behavior Supports) through the Department of Education at all public schools.
- In the six OMH regions, mental health school-based services are being offered in 118 schools, serving 16,580 persons for a cost of $3.6 million. LGEs offer school-based services as well.
- School-based social workers are being utilized in some areas of the state based on funding availability.
- Within the post-secondary educational setting, disability affairs staff is being exposed to supported education best practices by way of seminars and conferences.
- OMH, the Dept. of Education and other partner agencies continue to collaborate on expanding best practices.
- Nationally recognized Peer Support Specialist Programs, Wellness Recovery Action Plans (WRAP), Smoking Cessation programs and Wellness programs are being implemented statewide. These programs will be strong contributors to the enhancement of an individual's quality of life.

Strategy Two: Increase employment opportunities and supports for individuals with behavioral health conditions.

- Collaborative efforts among LRS, OMH, OAD, Department of Education, NAMI, MHAL, Social Security Administration, Governor's Office on Elderly Affairs and the Housing Authority addressed methods of expanding upon the evidenced-based practice of supported employment.
- Current efforts are focused on improving collaboration between LRS and OMH and other partner agencies.
- Yearly job fairs are ongoing.
- Additionally, the workgroup addressed the issue of transition-age youth and methods of alternative funding sources through Social Security Administration.
- Four Peer Support trainings have been conducted with 69 behavioral health clients trained with 25 employed.
- Mental health consumers in our system of care have been trained as WRAP facilitators and have been conducting groups in most areas of the state while being financially compensated.

Strategy Three: Increase opportunities for Permanent Supportive Housing, transitional housing, and mainstream housing and additional support services for individuals and families.

- Collaborative partners discussed methods of increasing permanent supportive housing sites statewide with housing authorities and other stakeholders.

- Housing authority assisted in identifying needs and barriers when working with landlords/contractors.
- Funding sources were researched for program implementation for all housing types as well as supports.

Strategy Four: Reduce social stigma of behavioral health conditions

- The reduction of social stigma continues to be an on-going challenge that many organizations have addressed through anti-stigma campaigns and educational opportunities within the communities statewide.
- MHAL has actively supported anti-stigma campaigns through the distribution of educational materials in addition to spearheading a public relations campaign for the community that included billboards and fliers.

Goal Six: **Define, establish, and sustain the leadership role of the Office of Mental Health in order to efficiently and effectively accomplish "bringing the hope of recovery to Louisianans with mental health conditions" as delineated in the "Louisiana Roadmap for Change".**

Strategy One: Ensure that the vision and the mission for the Office of Mental Health services reflect not only a recovery and resiliency orientation, but also that they include the concept and practice of integrating care through a coordinated network of providers/ stakeholders outside of the traditional MH systems (private providers, university systems, other state agencies, etc.

- OMH has adopted as its vision statement: "We envision a future in Louisiana where every individual has the opportunity to live a full, satisfying, and productive life in their community." Its mission statement is "OMH will advance a resiliency-, recovery- and consumer-focused system of person-centered care utilizing best practices and evidence-based practices that are effective and efficient as supported by data from monitoring outcomes, quality and accountability."
- Legislation was adopted during the 2009 Regular Legislative Session to merge the offices of Mental Health and Addictive Disorders into an Office of Behavioral Health. This will align the central office functions and structure in a fashion more consistent with the LGEs of human service districts/authorities. The DHH central office functions will focus on quality improvement, monitoring of program operations, implementation and sustainability of EBPs, workforce development, policy and regulatory oversight.
- HB 837 which would create the Office of Behavioral Health (OBH) includes a stakeholder committee to advise DHH on the development and implementation of the Office of Behavioral Health.

Strategy Two: Refocus the work of the Office of Mental Health both in response to the creation of comprehensive human service districts/ authorities and to facilitate the same.

- Act 373 allowed for OMH to respond to regions preparing to become comprehensive human service districts/authorities with the Human Services Accountability Plan. The Accountability Plan allows the statewide human services plan developed by DHH, in consultation with the Human Services Interagency Council which sets forth the criteria, process, timelines, guidelines for service delivery, clinical protocols, evidence-based practices, quality management and monitoring, data collection and reporting, performance outcome measures, information management, and readiness assessment protocols to be followed by the department and the districts.
- OMH will provide assistance to the regions in guidance with the "readiness assessment' process by which a survey team will review all areas of business management of the district to determine operational readiness based on a set of uniform criteria.
- Upon her appointment, OMH Assistant Secretary Jennifer Kopke began reorganizing the OMH Central Office to facilitate responsiveness to LGEs. She has placed special emphasis on the Central Office roles related to quality, accountability, evidence-based practices and workforce development.

Strategy Three: Develop a strategic approach- one that aligns the workforce planning and competencies with the vision and mission of the Office – that makes it possible to build leadership capacity now and for the future.

- A credentialing and privileging workgroup was formed to address competences and credentialing.
- A review of professional licensing and certification standards was conducted with State of Louisiana Licensing and Credentialing Boards.
- A cross-walk of service delivery definitions by professional credentialing and related billable service codes was created in collaboration with the Bureau of Health Services Financing.
- OMH centralized and formalized the process for credential verification of all prescribers working in OMH community programs.
- OMH elevated workforce development within its infrastructure and placed it under the same structure as the Division of Adult Best Practices and the Division of Child/Youth Best Practices.

Strategy Four: Develop capacity for the Office of Mental Health to provide technical assistance to local governing entities in the areas of program innovation and technology transfer, including working through the Human Services Interagency Council where appropriate.

- OMH, in collaboration with the HSID, OCDD and OAD has reviewed and updated the draft of the LGE Accountability Plan and the related performance measures. This plan is still in draft format, with the goal being common measures across program disciplines where feasible, and distinct measures within program discipline where appropriate.

Strategy Five: Develop capacity for the Office of Mental Health to ensure professional standards and program integrity throughout the mental health system inclusive of regions/ LGEs, including working through the Human Services Interagency Council where appropriate.

- See above. OMH is currently enhancing its ability to provide technical assistance by establishing a division of quality improvement and policy issuance, as well as divisions functioning as centers of excellence for adult and child/ youth services.

Strategy Six: Develop capacity for the Office of Mental Health to provide assistance to Regions/ LGEs in the area of data management and utilization, including working through the Human Services Interagency Council where appropriate.

- OMH has initiated the Service Process Quality Management (SPQM) data management initiative with all LGEs participating.
- OMH has taken steps to initiate a review of electronic health records and make recommendations to DHH regarding the various options.
- OMH continues to update the OMH Integrated Information System (OMH-IIS) by implementing electronic formats for scheduling, admissions, discharges, service tickets, and concurrent documentation of service plans.

Strategy Seven: Continuing service provision through its inpatient facilities, the Office of Mental Health will review its policies and processes to ensure integration of services and seamless service delivery within the larger continuum of care statewide.

- CEOs of four OMH hospital systems have collaborated to develop cross-hospital contracts for purposes of standardization and efficiency.
- OMH monitors, as a key indicator, the continuation of behavioral health services in the community system upon discharge from inpatient care.

Strategy Eight: Develop and implement a comprehensive financial strategy that transforms approaches to funding of behavioral health services in order to improve access and cost-effectiveness.

- Implementation strategies associated with building a functional Office of Behavioral Health will address financing strategies.

Cornerstone Project

Prior to the Hurricanes of 2005, the Office of Mental Health was aggressively pursuing accreditation for the OMH outpatient clinics. However, during the process it was recognized that the necessary infrastructure to support a quality organization was lacking; and certainly, this lack of infrastructure only intensified problems with the recovery from the storms. Thus, the decision was made to postpone temporarily the goal of accreditation in order to develop and implement the infrastructure to support the organization. "The Cornerstone Project" resulted from this sequence of events. The Cornerstone leadership team initially consisted of state office staff, a national consultant and the regional manager and medical director from each region. Meetings were held on a monthly basis with subgroups meeting in between those larger meetings.

The two major hurricanes that hit Louisiana in 2008 caused additional impediments to the progress within the Cornerstone project. Additionally, the national consultant who was assisting with the development and implementation of the project was nearing the end of her contract; and a new OMH administration had been installed. These factors required further modifications in the Cornerstone implementation process. Information on the four 'Cornerstones' and the status of the development of each project are listed below.

Recovery and Resiliency Cornerstone: The Office of Mental Health has made the decision to base the system of care on a recovery and resiliency philosophy. The goal of this cornerstone is the monumental job of not only training, but transforming the hearts and minds of the entire work force to embrace this new model of care. Thus far, the OMH leadership team has heard a presentation from Dr. Dan Fisher, a nationally known recovery leader and also has had an onsite visit to "The Village" a national center of excellence in the Recovery model. In June, 2007, OMH sponsored a broader training on recovery principles for about 150 clinical and administrative leaders within the OMH organization. Each region has begun to develop plans and implementation strategies specific to their own regions and clinics so that the model is shaped in ways that are meaningful to each region. Another part of this project has resulted in the initiation of peer support services from both the programmatic perspective and through efforts to obtain Medicaid funding for these services. OMH has trained 40 Peer Support Specialists who are now beginning to find employment within the outpatient clinics of the system. The Local Governing Entities (LGEs) and the OMH clinics have employed these certified Peer Support Specialists as support staff to assist consumers who arrive for their regular clinic appointments. However, the viability of this program has been severely affected by the budget cuts suffered by OMH, and the future of the program is uncertain at this time.

Utilization Management Cornerstone: Again with the help of a consultant, OMH has developed a utilization management (UM) system for the OMH clinics and for those LGEs who wish to participate. Standardized target population definitions, service definitions, client profiles, intensity of need criteria, priority determination, authorization criteria, and service packages are part of the UM system. One of the UM elements that has been implemented in the past year is centralized scheduling. Almost all clinics and some of the LGE clinics are using some form of centralized scheduling for their clients. OMH clinics are currently using Microsoft Outlook's calendar function for this purpose, but the plan is to build a centralized scheduler function into the OMH Integrated Information System (OMHIIS). Productivity standards for staff have been defined according to UM standards, and clinics have been encouraged to begin to schedule consumers based on these standards. To assist clinics to use the productivity data to make data-based decisions for their clinics, OMH has purchased an on-line analytical system, Service Process Quality Management (SPQM).

OMH has also hired a new consultant to train staff on the use of productivity and other clinical data using SPQM as part of an Accountable Care approach. Staff members are currently participating in monthly on-line 'Go-to-Meeting' conferences to train them on the use of SPQM and how to use the data generated to make clinical decisions that increase efficiencies. Use of the Level of Care Utilization System (LOCUS) criteria are established for the target population, intensity of need, and priority levels. OMH has purchased the electronic version of the LOCUS complete with training on the use of the LOCUS instrument. Training on the LOCUS state-wide began in July, 2008 and was completed in the fall. The implementation and use of the LOCUS was begun in October 2008. A Directive from the OMH Assistant Secretary now requires staff in the OMH clinics to conduct a LOCUS evaluation on all new admissions, again every 6 months, and when the person is discharged. This information is being used by the clinics to define their cases according to the UM target population criteria. All OMH clinics have completed a UM Readiness Survey and a UM Implementation plan. All clinics are now in the implementation phase of the UM / Accountable Care process. A Utilization Management Workshop was held for OMH Executive staff in June 2009, to brief them on the status of all Implementation plans and to design the plan for the next phase of UM implementation. The UM process is now under the direction of one of the Division Directors in OMH Central Office. There are UM teams in each OMH Region, and the UM Central Office Director has regular contact with them to guide them and to provide them with technical assistance where needed to support the continued implementation of UM / Accountable Care.

Credentialing and Privileging Cornerstone: In addition to the traditional credentialing model from the hospitals, a credentialing plan has been completed for the clinic medical staff, and a credentialing plan to include a competency assessment program for other licensed treatment staff is in progress. The completion of this cornerstone will result in a credentialing plan for all licensed independent practitioners. Manuals will be developed containing all of the accompanying policies for credentialing licensed staff within the Office of Mental Health. A contractor has been hired to complete the policies and do the initial credentialing of OMH employees. This contractor has established a credentialing system for all OMH staff members who prescribe medications. Credentialing is being monitored and maintained by this contractor. During creation of the UM implementation plans, the OMH consultant assisted staff in the regions to construct competency requirements for each of the UM Core Services. Centralized credentialing will be maintained with regional staff involvement.

Performance Improvement Cornerstone: This cornerstone will result in the development of a comprehensive performance improvement plan so that data driven decisions will be the norm. Work on this cornerstone has not yet begun, but the foundation for this part of Cornerstone is being established by the recent purchase of SPQM as the means to use the data in the OMH data warehouse as part of an ongoing performance improvement process.

The President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America, and the OMH Policy for Block Grant Proposals and Allocations

The *President's New Freedom Commission* Goals were utilized in the development of an Office of Mental Health Policy (Policy # 0032006) entitled 'Block Grant Proposals and Allocations' that was signed and implemented in January of 2006. The Policy was developed conjointly with OMH staff and the Planning Council. The purpose of the policy is to ensure that an inclusive system for the effective and efficient allocation, expenditure, monitoring, and accounting of Block Grant funds is in place. The procedures outlined in the policy are designed to promote accountability to the Center for Mental Health Services (CMHS), the Mental Health Planning Council, and the Office of Mental Health executive management. Of significance in priority setting, the policy directs that all proposed expenditures in each Intended Use Plan be listed according to established categories. These categories have been cross-walked with the six Goals of the *New Freedom Commission* to promote awareness of the needs in each category, as well as to emphasize these categories as priorities. The Crosswalk Tables are below, separated into Adult and Child/ Youth categories. The reader is also referred to the Appendix to see the actual monetary allocations in each of the Intended Use Service Types; as well as to Adult Section, Criterion 5, Table C.

PRESIDENT'S NEW FREEDOM COMMISSION & LOUISIANA OMH INTENDED USE CATEGORIES - ADULT SERVICES CROSSWALK -

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**Adult Service Category**	**Intended Use Service Types**
2	Mental Health Care is Consumer & Family Driven	Adult Employment	Employment Programs; Employment Development & Services
2	Mental Health Care is Consumer & Family Driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1 **2**	Americans Understand that Mental Health is Essential to Overall Health Mental Health Care is Consumer & family driven	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support; Supported Adult Education
2	Mental Health Care is Consumer & family driven	Consumer Liaisons	Consumer Liaisons
2 **5** **6**	Mental Health Care is Consumer & family driven Excellent Mental Health Care is Delivered & Research is Accelerated Technology is Used to Access Mental Health Care & Information	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
2 **4**	Mental Health Care is Consumer & family driven Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Consumer Support Services	Consumer Initiated Programs; Community Care Resources; Community Resource Centers; Case Management; Consumer Support; Medicaid Enrollment; Consumer-Education, Support and Empowerment
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 hour screening & assessment; Mobile crisis response

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**Adult Service Category**	**Intended Use Service Types**
1 **3** **4**	Americans Understand that Mental Health is Essential to Overall Health Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program; Co-occurring Disorders Treatment
2 **6**	Mental Health Care is Consumer & family driven Technology is Used to Access Mental Health Care & Information	Planning Operations and System Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
2	Mental Health Care is Consumer & family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Services and Supports
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OMH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2 **3**	Mental Health Care is Consumer & family driven Disparities in Mental Health Services are Eliminated	Transportation	Community / Rural Transportation
3 **4** **6**	Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice Technology is Used to Access Mental Health Care & Information	Other Contracted Services	Comprehensive Mental Health Services; Management Information System; Infrastructure Development; PODS (Public Outreach Depression Screening); Forensic Services

PRESIDENT'S NEW FREEDOM COMMISSION & LOUISIANA OMH INTENDED USE CATEGORIES - CHILD/ YOUTH/ FAMILY SERVICES CROSSWALK -

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**C/Y Service Category**	**Intended Use Service Types**
2	Mental Health Care is Consumer & Family driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1 **2**	Americans Understand that Mental Health is Essential to Overall Health Mental Health Care is Consumer & Family driven	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support
2	Mental Health Care is Consumer & Family driven	Consumer Liaisons	Consumer Liaisons
2 **5** **6**	Mental Health Care is Consumer & family driven Excellent Mental Health Care is Delivered & Research is Accelerated Technology is Used to Access Mental Health Care & Information	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 Hour Screening & Assessment; Mobile Crisis Response
2 **4**	Mental Health Care is Consumer & family driven Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Family Support Services	Family Support Services; Wraparound; Medicaid Enrollment; Family Support Liaison and Program; Parent Liaisons; Family Training; Parent / Family Mentoring; Nurse Visitation Program; Community Care Resources; Rural Mobile Outreach Programs; Therapeutic Camp

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**C/Y Service Category**	**Intended Use Service Types**
2 **6**	Mental Health Care is Consumer & Family driven Technology is Used to Access Mental Health Care & Information	Planning Operations and Systems Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
2	Mental Health Care is Consumer & Family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Programs
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	School-Based Mental Health Services	School-Based Clinics; School-Based Services; School Violence Prevention
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OMH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2 **3**	Mental Health Care is Consumer & Family driven Disparities in Mental Health Services are Eliminated	Transportation	Community / Rural Transportation
3 **4** **6**	Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice Technology is Used to Access Mental Health Care & Information	Other Contracted Services	Comprehensive Mental Health Services; Nurse Home Visitation Program; Management Information Services; Infrastructure Development; PODS (Public Outreach Depression Screening)

Criterion 1: Comprehensive Community-based Mental Health Services

The effort to provide an improved and seamless system of services is an ongoing goal for the Office of Mental Health. Service and system integration at the local level as well as the organizational level continues. This is shown most poignantly in the merging of the Offices of Mental Health and Addictive Disorders described earlier. Additionally, the integration of the acute psychiatric inpatient hospital units with the various community based programs continues, utilizing the Louisiana State University (LSU) Medical Center administration's help and commitment. OMH and the LSU hospitals have implemented statewide and local agreements that govern the roles and responsibilities of the two organizations in their collective efforts at developing a more comprehensive range of acute care services for adults. This agreement addresses budgetary, clinical, and human resource issues.

Mental health services for individuals and families who come before the State's criminal, family, and juvenile court systems are inadequate. In-odd numbered years, the Louisiana Legislature holds what is called a 'fiscal only' session; and therefore, in the 2009 Regular Session of the Legislature, primarily bills of a fiscal nature were considered. However, a few bills that had forensic impact were entertained.

- HB 713 proposed to provide for a court-mandated treatment program for the treatment of sexually dangerous persons. After examination of the fiscal note, this bill was withdrawn. But, a related bill, HB 366 was signed into law (ACT 205), and provides for the supervision of sex offenders by extending supervised release of certain sex offenders for life, and amends procedures governing the supervision of sexually violent predators and child sexual predators. This bill also affords the use of GPS tracking technology to monitor location and movements of those individuals who are identified as sexually violent predators.
- Another bill, ACT 230 (SB 61) allows the Department of Health and Hospitals to use appropriate restraints on the person of a child during transport, after finding that a child is incompetent to proceed pursuant to a felony charge, and/or upon a showing of good cause that a child presents a danger of flight. Use of restraints must comply with the policy of the Department of Health and Hospitals on seclusion and restraints.
- ACT 272 authorizes testimony by simultaneous transmission through audiovisual equipment, if such technology is available in the courtroom, during any criminal proceeding, juvenile or family court proceeding which is of a criminal nature, and any civil forfeiture proceeding arising from alleged criminal activity.

The trend continues in which increasing numbers of civil psychiatric beds are being used for forensically-involved persons, thereby limiting access to inpatient psychiatric care for the general population. More than a majority of the existing civil inpatient service capacity is constricted by the demand for forensic inpatient services. Despite the addition of additional forensic beds for competency restoration and the implementation of competency restoration services in the parish prisons and the implementation of a juvenile competency restoration program, the lack of community

based resources for managing the forensic population prevents discharging a sufficient number of those in the forensic facility who would otherwise be eligible. Judicial restraint on approving such releases also creates a 'back door' barrier which directly affects access and creates a sustainable and growing forensic waiting list.

Access to medications has historically been difficult due to the limited number of psychiatrists working in the clinics. OMH now has a policy that allows non-physician professionals who have prescriptive authority to prescribe within OMH facilities. The inclusion of Medical Psychologists and Advance Practice Nurse Practitioners allows patients and consumers greater access to the care they need. Several mental health clinics have taken advantage of this added resource to the benefit of their consumers.

The Office of Mental Health has a formulary that includes all of the newer antipsychotic agents, antidepressants, and mood stabilizers; however the cost of these medications is often high. Thanks to the efforts of outpatient clinic employees, the Office of Mental Health has capitalized on the available Patient Assistance Programs (PAP) to offset the cost of providing medications to OMH outpatient clinic clients. The cost of 70% of outpatient medications is underwritten by PAP. Staff members have also assisted all clients who are eligible with obtaining Medicare Part D or Medicaid benefits. In the past few years, these efforts have resulted in a savings of approximately $5 million each year from the six Regions alone. It is estimated that OMH pharmacies have dispensed over $9 million worth of prescriptions from Patient Assistance Programs and sample medications during each of the last two years; and that local community pharmacies have dispensed medications valued at roughly an estimated $20 million utilizing Medicaid and Medicare funding to OMH clients.

OMH has recently restructured its psychotropic medication formulary in another attempt to reduce costs. The Pharmacy and Therapeutics Committee along with a special committee composed of Regional Medical Directors developed a step-wise algorithm for the use of medications from various classes. The current algorithm is detailed below:

OMH ALGORITHM FOR THE USE OF ANTIPSYCHOTIC, MOOD STABILIZERS, AND ANTIDEPRESSANT MEDICATIONS

ANTIPSYCHOTICS

- Preferred
  - Generics
  - First generation antipsychotics (FGAs) when possible
- Medical Director approval required
  - Use of 2 atypicals
    - Criteria for approval: 1) a trial of 3 single atypicals for sufficient length(s) of time; 2) a trial of a single atypical and FGA for sufficient length(s) of time
  - Invega
    - Criteria for approval: 1) a trial of 3 single atypicals for sufficient length(s) of time, including risperidone; 2) trial of at least 1 combination of an atypical and a typical
  - Abilify (>30 mg)
    - Criteria for approval: 1) sufficient trial of Abilify (<30 mg); 2) sufficient trial of generic atypical or FGA
  - Zyprexa (>40 mg/day)
    - Criteria for approval: 1) sufficient trial of generic or FGA
  - Seroquel
    - Not approved for use under 200 mg
    - Criteria for approval over 200 mg: 1) sufficient trial of generic or FGA

- Geodon
  - Criteria for approval: 1) Sufficient trial of generic or FGA
- Risperdal Consta
  - Inpatient: only for patients preparing to be discharged
  - Outpatient:
  - Criteria: Sufficient trial of generic or FGA
- Rapid oral Second Generation Antipsychotics (SGAs)
  - Zydis
  - M Tab

MOOD STABILIZERS

- Preferred
  - Generics
- Medical Director approval:
  - Topamax (seizure disorder only)
  - Neurontin (seizure disorder only)
  - Depakote ER

ANTIDEPRESSANTS (for anxiety, depression, ADHD)

- Preferred
  - Generics
    - Fluoxetine
    - Sertraline
    - Buproprion
    - Citalopram
    - Etc.
  - Medical Director approval
    - All other antidepressants

PROCEDURES

- Hospital and regional medical directors must approve all medications and specific usages of medications noted above within the "Medical Director approval required" categories.
  - Medical directors will keep records for each contact requesting approval for specific medication use
  - Medical directors will report each month to the OMH medical director requests for specific use and outcome of each action on the specific UM form that has been developed for monitoring these reviews
  - OMH medical director will review each action and will work closely with medical directors in the implementation of these procedures
- Hospital medical directors will develop a system of "rounds" attended by treating physicians/prescribers and pharmacy directors, among others, to ensure that information about medication cost and the cost of possible alternatives is available to the clinician.
  - Patients admitted to OMH clinics taking (previously prescribed) medications requiring medical approval or prohibited will be allowed to continue the medications without medical director approval for 3 months, during which time the physician/prescriber will work with the patient to discontinue the prohibited medication (transfer to a non prohibited medication) and, as much as possible, the medications that require medical director approval.
- Specific budgetary targets will be developed for each region and hospital. Progress toward achieving expected targets will be monitored during the course of the fiscal year so that additional formulary changes can be made, if necessary.

A significant administrative change has occurred with the Mental Health Rehabilitation (MHR) program that removes the oversight of the program out from under the OMH. MHR remained under the management of the Office of Mental Health through June 30th, 2009; but as of July 1, 2009, the oversight and management of the program was transferred to the DHH Bureau of Health Services Financing/ Medicaid. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting on that date, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities. During its last year in OMH, the Mental Health Rehabilitation (MHR) program continued to provide services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. The available services included Assessment, Reassessment, Community Support, Group Psychosocial Skills Training, Counseling, and Medication Management. Optional services for children/ youth are Parent Family Intervention-Intensive, which provides intensive home-based services to assist children who are at-risk of being placed out of their homes. All authorized providers in the network are required to be accredited by JCAHO, CARF, or COA.

Cultural and diversity needs in the service delivery system are under-developed, as are the special needs of the transitional age and older adult population. Service providers with specialties in these areas are under-represented, and there is need for more staff training. These areas are receiving more emphasis.

The Office of Mental Health's (OMH) statewide Cultural and Linguistic Competence Planning Committee began its work with an initial meeting in April 2005. The committee of approximately 35 people was representative of the whole state, consisting of members from each Region and LGE in the state; and included mental health professionals, persons with mental illness, family members and mental health advocates. The Cultural and Linguistic Competence Committee involves persons with mental illness and family members fully in its work, including sharing in decision-making, as emphasized in Goal #2 of the *President's New Freedom Commission Report*. The committee began research on the number of persons with mental illness being served around the state (by race, ethnicity, gender and age), the numbers in the state based on federal estimates, and the number being served in the non-profit sector statewide. After this data gathering phase, the committee reviewed data regarding staff demographics, clinic locations, accessibility, etc. to begin to determine cultural and linguistic competence issues and disparity issues in OMH, addressing Goal # 3 of the *New Freedom Commission Report*. The committee changed its immediate focus in response to the 2005 hurricanes. A statewide meeting was scheduled soon after the worst of the storm emergencies were over. The committee agreed to focus on hurricane related cultural and linguistic competence issues across the State since the entire population of approximately 485,000 in New Orleans was dispersed.

The National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA) pledged on-going *pro-bono* consultation to assist Louisiana in developing cultural and linguistic competencies. NAMBHA utilized the Center for Mental Health Services' nine guiding principles for cultural competence in disaster mental health programs as their guide, as well as data and information gathered from focus groups. Workshops were developed to assist first responders and other professionals in improving their cultural competencies. NAMBHA provided Louisiana with an exemplary set of tools and offered necessary technical assistance to help people working with survivors of the hurricanes gain the cultural knowledge and skills needed to effectively perform their jobs. Trainings have since been held across the state. One of the primary learning objectives was to train staff that cultural and linguistic competence is a journey and a process; and the most ardent

champion spends a lifetime acquiring skills that continue to make them more culturally competent. The trainings have begun to create change at a system level that facilitates change at an individual level as well as at an organizational level. These changes at a minimum produce improved outcomes, decrease disparities, and diminish barriers. In addition, there is a focus on the positive characteristics of groups of people built on the strengths of minority communities. Since the Committee's inception, it has researched fragmentation, gaps in care, and mental health disparities, with an emphasis on the effects of trauma from the hurricanes on persons with mental illness and the communities that received these individuals after they were displaced. The Cultural Competence Plan is being used to guide, monitor and evaluate cultural and linguistic competence, so that citizens can receive appropriate services to reorganize and rebuild their lives.

OMH continues to explore is ability and capacity to expand the provision of evidence-based practices (EBPs). The State has isolated pockets where evidence-based practices are in place, but the practices have not been brought to a state-wide scale. Further complicating the situation is the fact that funding for continuing the EBPs is limited, and as a result, sometimes the programs are disbanded.

Crisis intervention and the development of resiliency in children and youth is an important area of need. In an effort to begin to address this need, the Child/Adolescent Response Team (CART) was developed. The CART response process is a time-limited series of crisis intervention steps. The six phases of the CART approach to crisis intervention consists of a cluster of services available to children and families initiated through a crisis phone line. The crisis plan establishes a time-line addressing all necessary elements (i.e., least restrictive setting issues, family supports, transportation, etc.) and includes a plan to link the family back to any pre-existing resources or new resources as needed. There are now crisis services for children statewide, although two LGEs (JPHSA and FPHSA) utilize their own model of crisis intervention for children.

Reducing the impact of maternal depression and the potential for inadequate parenting is one facet of a program sponsored by the Louisiana Department of Health and Hospitals and the American College of Obstetricians and Gynecologists – Louisiana Section. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) program is designed to address poor birth outcomes in Louisiana by reducing the use of alcohol, tobacco and illicit drugs during pregnancy. The program also screens and provides appropriate referral for domestic violence and depression in pregnancy. Specific SBIRT programs have been expanded to include Lafayette and Lake Charles. The expansion of this program is an important step toward healthier outcomes for our state's most vulnerable citizens by assisting pregnant women in receiving the treatment they need. The women are screened within medical settings by a physician, nurse or clinician who identifies women at-risk for substance abuse or depression and other related problems through a questionnaire process. The system provides for brief intervention or brief treatment, and refers those identified as needing more extensive services to a specialist.

Additional programs are also in place that address the need for a more integrated approach to care. Although the separation of treatments for mental illness and substance abuse is still all too common in the State, several initiatives primarily funded through competitive grants, are underway to address this unnatural division of services. With the awarding of the Co-Occurring State Infrastructure (COSIG) Grant, OMH and the Office of Addictive Disorders began working together to move the state's behavioral health system into well-coordinated systems of care that treat both substance abuse and mental illness in a seamless way. The original focus of COSIG was on adults, but there is some inclusion of the child/youth population, since the state did not receive the CASIG Grant. The

majority of infrastructure changes that are currently occurring as a result of COSIG will have a direct effect on all persons receiving mental health and addictive disorder services regardless of age.

Recent legislation has begun the administrative integration of OMH with the Office for Addictive Disorders to form the Office of Behavioral Health. This reorganization is expected to be the foundation for promoting better integration at the clinical level. In several areas throughout Louisiana, local clinics have independently reorganized their services into a more integrated model. Many of the local areas have embraced evidence-based practices and have recognized that integrated care should be the standard. Local areas have also acknowledged the cost savings that occurs with integrated care; this is particularly inviting given the recent economic downturn on the tail of the state's continued hurricane recovery.

Adequate, safe, and affordable housing, already a problem in the state, became a major obstacle after the 2005 hurricanes, and to a lesser, but significant degree after the 2008 hurricanes. There has been widespread devastation and destruction of housing both in rural areas, and in highly populated areas hit by the hurricanes. Serious mental illness and substance abuse continue to be the two most significant factors contributing to homelessness in the State. There is a lack of affordable housing, especially for people with disabilities, and this situation has been exacerbated by the impact of the hurricanes. The need for rental subsidies to assist people with disabilities who are homeless due to the skyrocketing housing costs post-disaster is evident. The recent decrease in FEMA-funded housing has again put people into the homeless category who were housed in motels and trailers for several years after Hurricane Katrina/ Rita. Aside from the dire need to create a new stock of affordable housing to replace that lost in the hurricanes, there is a considerable need for community based support services to assist people with mental illness in attaining and retaining their housing. At a minimum, an increase in available outreach programs, such as those provided through the Projects to Assist in the Transition from Homelessness (PATH), that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed. Funding through the PATH program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder.

The Department of Social Services (DSS) annual Needs Assessment/ Shelter Survey is an unduplicated statewide count of the numbers of homeless individuals served by the homeless shelters in the state for the year. The State DSS is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, DSS compiles an annual report on the unduplicated numbers served in shelters across the state. The survey is a twelve month unduplicated count of persons using the state's shelter system. It also includes a point-in-time count that examines the subpopulations represented in the shelter count and the reasons for homelessness. For this report, the 2008 Shelter Survey data was used. There are 153 shelters in the DSS database. In 2008, the number of shelters that reported was 119 or 78% of the total. The data revealed that the yearly total of homeless persons served was 32,112. The sub-population breakdown is significant because it captures the count of those individuals who have co-occurring mental illness and addictive disorders and those who have a single disorder.

The Shelter Survey data indicated the following for the sub-populations:

- Severely mentally ill- 3,927 (12.23%)
- Chronic homeless- 6,072 (18.91%)
- Dual Diagnosed- 4,942 (15.39%)
- Substance Abuse- 9,309 (28.99%)
- Veterans - 3,692 (11.5%)
- Elderly- 1,441 (4.49%)

A lack of appropriate education directly impacts the ability of adults and youth with mental health disorders to find employment, and these individuals are oftentimes unemployed and underemployed. OMH remains invested in providing school-based mental health and health-related services in academic settings. OMH has a Memorandum of Understanding with the Special School District #1 of the Department of Education to provide educational services to children and youth hospitalized in an OMH facility.

Educational and employment activities are directly linked with one another. There have been multiple initiatives centered on the employment of individuals with psychiatric disabilities and many of the recommendations included educational/transition components. The Louisiana Commission on the Employment of Mental Health Consumers sunsetted in June 2007, and the Louisiana Plan for Access to Mental Health Care ended in 2008. Both initiatives developed recommendations for collaboration and programs intended to improve transition and employment outcomes for individuals with psychiatric disabilities. These groups convened a variety of stakeholders and collaborative partners to work on implementation of various goals related to the service spectrum for individuals with mental illness. Though both workgroups have since terminated, the OMH continues to work on collaboration and program implementation that is based on the issues identified through each of the workgroups. Some of the more immediate collaborative efforts include work with Louisiana Rehabilitation Services (LRS) and the Department of Education (DOE) working on transition projects, positive behavior supports (PBS) and suicide prevention activities.

Educational services are also offered through the Early Childhood Supports and Services program (ECSS) - located in CAHSD, MHSD, FPHSA as well as Regions 3, 4, 7, and 8 and Louisiana Youth Enhancement Services (LaYES - located in MHSD). Services offered that improve parent- child relations, who assist students with job-related skills, such as social skills, safety practices in the work place, and a broad range of issues related to behavioral, emotional, and mental health that are fundamental to adolescent development and educational attainment. Referrals are routinely made to assist youth maintain their educational goals, by the the Mental Health Rehabilitation (MHR) program, case management, and ACT-type programs, Multisystemic Therapy (MST) is being integrated into the state system of care, having been approved as a Medicaid reimbursable service. Currently, there are 11 providers in state, covering all but one Region of the state. The MST program does not directly provide educational services, but it supports them through social skills training, and the removal of family and environmental barriers preventing a client from achieving educational goals.

Following Hurricanes Katrina and Rita in 2005, the school system was virtually destroyed in several parishes. Approximately 500 schools were damaged and 80 were destroyed. The Department of Education has continued to re-open schools in stages as facilities were repaired and faculty and staff

became available. Schools have continued to benefit from mental health and stress management support for faculty, staff and students through Louisiana Spirit. Louisiana Spirit continued to provide services geared towards the mental health recovery of educational staff, students, and their families in the aftermath of hurricanes Gustav and Ike that hit the Gulf Coast in 2008.

Better coordination of mental health, medical, housing, recreational and employment services for consumers with mental illness is necessary to fit the needs and individual aspirations of persons with severe mental illness. Interagency agreements, proactive use of legislation, the utilization of outside funding to build full service, regional resources for mental health consumers, with the ability to provide, coordinate, and adjust services needed by that population will improve the care that citizens with mental illness will receive.

An increase in the number of suicide attempts and completed suicides among victims of the hurricanes has been noted, increasing the urgency and importance of addressing the hopelessness that precedes suicide. The Louisiana Partnership for Youth Suicide Prevention, funded by a SAMHSA grant is designed to address this leading cause of death among Louisiana's youth and young adults. The initiative advances strategies of the Louisiana's Youth Suicide Prevention Plan, and strengthens public and private partnerships, cultivates community efforts, mobilizes existing resources, expands gatekeeper training, and increases awareness of youth suicide and suicide prevention efforts. The project targets 10,000 youth and young adults (10 – 24 years old) who are middle, high school, and college students who were directly affected by Hurricanes Katrina and Rita. The grant provides $300,000 annually over a three-year period to provide services in the hurricane-impacted parishes of Calcasieu, Cameron, Jefferson, Orleans, Plaquemines, St. Bernard, Lafayette, Vermillion, and also to evacuees who live in East Baton Rouge Parish.

The percent of consumers discharged from state psychiatric hospitals and re-admitted within 30/180 days of discharge reflects the degree of recidivism. Post-hurricanes, this data could be misleading at first glance. Due to the fact that there are fewer beds because of the closure of some facilities, and the beds are filling as soon as they are emptied, a patient who would previously have been re-admitted based on their mental health status may be forced to wait a longer time for a bed to become available. Thus, the numbers may not necessarily be meaningful or comparable to previous measures. While it was initially anticipated that recidivism would increase, this may not be reflected in the data. As can be understood from this sort of example, the interpretation of all data that is collected post-storms is challenging.

Criterion 2: Mental Health System Data Epidemiology

Review of the number of persons served relative to estimated national prevalence rates is the most common means to determine the extent to which services are covering the need in terms of gross numbers of persons served. Services to adults are a critical area of need in the OMH system. Prevalence estimates indicate that only a small proportion of the need is being met by existing OMH services. Of the 85,873 adults with serious mental illness (SMI) in Louisiana, OMH reported a caseload of 26,953 adults in 2009 (as of 6/30/09, not including JPHSA). It should be noted that SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. The inclusion of individuals who have *any* type of mental illness would increase the population figures, but not the numbers of individuals served, as the OMH facilities are designated to serve only those individuals with SMI as the term is used in Louisiana. Creative and cost-effective ways of reaching increased numbers of Louisiana citizens in need must be found.

Although services directed towards children and adolescents are improving, they also remain a critical area of need in the OMH system. Prevalence estimates indicate that only a small proportion of this population is being met by existing OMH services. Of the 99,718 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OMH reported a caseload of 3,698 children and youth in 2009 (as of 6/30/09, not including JPHSA). SED/ EBD is a national designation that includes only those individuals suffering from the most severe forms of behavioral disorders. As reflected with the adult figures above, those who have any type of behavioral problem would increase the population figures, but not the numbers of individuals served, as our facilities are designated to serve those individuals with SED/ EBD.

Information with which to effectively plan and distribute resources is collected in numerous ways in the OMH. These various methods are briefly described in this section. Database upgrades that will combine information currently found in existing, separate databases into one efficient and comprehensive system is ongoing. With progressive implementation of the Office of Mental Health Integrated Information System (OMH-IIS) legacy systems are being phased out in favor of one, comprehensive, integrated web-based information system.

There also exist program specific data systems that are supported by OMH. These include the CRIS data system for the Child and Adolescent Response Team (CART), the ECSS-MIS web-based system for the Early Childhood Supports and Services (ECSS), the RiteTrack (proprietary) information system supporting the Louisiana Youth Enhancement Services (LA-YES) in New Orleans, and data system supporting the Louisiana Spirit Crisis Program. In each case, these specialized service programs have unique database needs that have been established by either building a suitable database "in-house" or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, the structure and data formats are compatible with OMH-IIS such that key clinical information can be uploaded to OMH-IIS which is the primary repository of this information for OMH.

The variety and extent of data collected provides rich and unique opportunities for objectively evaluating and improving the mental health care system in Louisiana. The C'est Bon and LaFete Surveys are the consumer-to-consumer methodology developed by Louisiana for collecting information to measure access, quality and outcome indicators

The "C'est Bon" adult consumer survey has resulted in interviews of over one thousand consumers during FY09 and has repeatedly been a rich source of information regarding needs from a consumer and family perspective. Called "La Fete", a comparable survey from parents and families of children with emotional/behavioral disorders was initiated in 2002 and continues. During the spring of 2005, La Fete piloted the use of the Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F). This MHSIP recommended survey instrument was implemented for the La Fete surveys conducted during the next survey cycle that began in the fall of 2005. Key informant reports by managers, consumers, service providers, and planning council members are also an important source of data. For 2007, the C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and was implemented in the summer of 2007. The YSS-F was modified to add one question that was missing from the standard YSS-F instrument posted on the MHSIP website. Now, the state has been using the standard MHSIP survey for adults and the standard YSS and YSS-F for youth and families respectively. A further enhancement to the state's

consumer survey process was made to add items of social connectedness, functionality, and school attendance on the C'est Bon Survey starting in July of 2008. Due to the low sample sizes obtained for the LaFete Child/Parent surveys, OMH will use this comprehensive data collection process for the entire quantitative portion of the LaFete survey which should improve the ability to collect adequate survey samples per clinic and also allow data collection state-wide annually, which has not been possible under the current LaFete survey process. A new methodology for collecting information on client outcomes is in the planning and implementation stage. OMH will use the Telesage Outcome Measurement System (TOMS). The TOMS is scheduled for implementation in FY 2010 as an objective of the Data Infrastructure Grant (DIG). This on-line tool allows multiple methods of data entry including direct entry by staff, voice entry, or touch screen.

The Office of Mental Health has developed a tool for measuring outcomes of clients receiving services in its mental health clinics. The Psychosocial Outcomes Monitoring Scales (POMS) is administered to adult clients by specially trained clinicians at admission, every 6 months during treatment and at discharge or any change to another level of care. This instrument allows the Office to collect data that can be used to determine effectiveness of services delivered as well to report on indicators for the Block Grant, the SAMHSA National Outcomes Measures (NOMS), and for reporting on indicators to the Louisiana legislature. A self-report version of this instrument was developed and briefly field tested. Prior to implementation of this instrument, the OMH embarked on a transformation of its service delivery system based on a Utilization Management (UM) model. Within this context, data that was normally collected at baseline by the POMS, will now be embedded within the new process of screening and assessment under UM. The TOMS, as previously described, will eliminate the need to embed the POMS items in the screening and assessment process and will also be used to capture outcome information on youth. This comprehensive survey system will allow OMH to collect data related to client level outcomes as well as capture all data needed for reporting on the NOMS and other performance measures.

Called the Survey of Regions and Districts, and the Survey of Hospitals, standardized survey forms are used to gather extensive information from the OMH hospitals and the regions/ LGEs statewide. Information gathered is available for inclusion in the annual Block Grant Application and other grant proposals, as well as for planning of resources, workforce delivery, etc. The instrument was carefully crafted and is continually updated with the goal of both increasing the validity of the information reported. This survey form is completed annually and submitted electronically.

The Office of Mental Health continually reviews several sources of data for determining gaps and unmet needs. Numerous quality indicators are obtained from the OMH Quality Management Report that is updated on a quarterly basis. The data in this report was formulated from recommendations from the Mental Health Statistics Improvement Program (MHSIP). Specific data requests can be made via Data Quest, the web-based ad hoc analysis/reporting system developed by OMH for decision support.

Criterion 3 - Child/ Youth *(Criterion 3 not applicable to Adults)*

The mental health care needs of children and youth are important to the future of Louisiana and they are becoming a higher priority in the state. As a result, there are many programs developing across the state that target the needs of this population.

Louisiana received a series of service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration - Center for Mental Health Services following the natural disasters that impacted Louisiana in 2005, and then again following the hurricanes of 2008 (Gustav and Ike). The state is attempting to find means to sustain funding in critical areas of need.

Louisiana Spirit is the project name of Louisiana's hurricane crisis counseling recovery program. The program began in 2005 after hurricanes Katrina and Rita; at the present time, it continues under a crisis counseling program grant after Hurricane Gustav. Gustav struck Louisiana on September 1, 2008 as the Katrina and Rita grant services were phasing out. Currently, the program continues to provide short-term, community-based crisis intervention, support, referral services, and other related activities and trainings to individuals, families and providers who were impacted by Hurricane Gustav. The Office of Mental Health has continued to provide administrative oversight and guidance for this program; direct services are provided at the regional level through Service Areas that are administered through the State instead of providers. The Service Areas are basically the same geographically as those utilized by the Office of Mental Health.

As a community based program, LA Spirit services are provided where the survivors are located. Crisis counselors provide crisis counseling, psycho-social education on the impact of disasters and stress management techniques to cope with distress in the aftermath of the disaster. Louisiana Spirit works closely with existing community resources to coordinate services for persons in need of services. Clients are supported and empowered to take an active role in their own recovery process. The program is designed to be a short term bridge of support for the survivors to local community resources. During this grant, regional mental health clinics have provided office space and/or use of some equipment for the staff of the service areas whenever possible.

Louisiana Spirit outreach crisis counseling services for children and youth provide education and information to parents and caregivers about signs of distress to be aware of in children as well as how to handle them and referrals to appropriate Mental Health resources. It can also include a short term series of face to face meetings with children, youth and their families focused on assisting the family to cope with their trauma and return to their previous levels of coping. On a present-focused, short-term basis, children, youth, parents and caregivers are supported and empowered as they recover from the impact of the hurricane. Although outreach crisis counseling services are community based, the services are not appropriate for life threatening or mandated reporting situations.

Under the Gustav grant, some of the children being provided Crisis Counseling Program Services have transitioned into Specialized Crisis Counseling Services (SCCS) to assist in meeting their ongoing psychosocial and educational needs. Counselors provide basic psycho-education sessions on coping, problem solving, social skills, anger management, trauma reactions, conflict management, adjustment, and other identified skills development areas of which children require more intensive support.

The Specialized Crisis Counseling component of Louisiana Spirit's CCP has been instrumental in focusing counseling and resource linkage efforts on specific needs of children and their families. This program has afforded children and their families opportunities to deal more assertively with the various problems that are hurricane related or problems that have been exacerbated by the hurricane experience. The approach by counselors and resource linkage coordinators has been one of a strengths-based, empowerment and solution-focused approach. Children and their families are taught the necessary skills needed to deal effectively with the various problems they present with and how to work on manageable goals that will enhance their current overall wellbeing while moving them closer to improved psychosocial and emotional recovery.

Louisiana continues to have two specialized programs specifically designed for children and their families. These programs are known as Early Childhood Supports and Services (ECSS) and LaYES. ECSS is a multi-agency prevention and intervention program that promotes a positive environment for learning, growth, and relationship building for children. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and the use of emergency intervention funds. ECSS also serves to build the infrastructure of the Parishes it serves by training human services professionals, agency personnel, educational and childcare personnel as well as family members and advocates in the specialized area of Infant Mental Health assessment and intervention. ECSS serves children from birth through 5 years of age and their families who have been identified as at risk for developing social, emotional, and/or developmental problems. Risk factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty, and having developmental disabilities.

Having added Caddo Parish during the 2009-10 Fiscal Year, ECSS provides or will provide Intensive Mental Health training to 21 or more service providers who will in turn provide infant mental health intervention to children 0 through 5 in ten sites providing services in fourteen parishes. ECSS screened 2,529children between the ages of 0 through 5 for risk factors that may lead to social/ emotional problems later in life. ECSS developed 934 multi-agency service plans for children and their families between the ages of 0 through 5 in the 14 parishes ECSS serves. ECSS referred 699 children to the infant mental health teams for assessment and possible infant mental health intervention.

The Children's Initiative Grant (LA-YES Louisiana Youth Enhanced Services Consortium and System of Care) incorporates a comprehensive and coordinated system of care for children with serious emotional disorders. LA-YES provides a community-based service system that is child centered, family focused, and culturally and linguistically competent. It has an Administrative Service Organization (ASO) that provides systems integration via direct care management services utilizing wraparound principles and practices, and the development, training, regulation, and monitoring of a Provider Network. This network array of mental health, social, and support services utilizes the LA-YES consortium and supports its goals of: providing culturally and linguistically competent social services; involving families in all levels of the delivery system; increasing access of the target population; developing a comprehensive system of care; generalizing evidence-based practices; providing early childhood intervention and prevention of emotional and behavioral problems; facilitating the provision of a broad array of mental health and other related services, treatments, and supports; and increasing awareness that mental illness affects children, adolescents and youth transitioning to adult systems. The care system confronts the access barriers to improve

the needs of children: racial and ethnic disparities, fragmentation of services, an over-reliance on end-stage care, a lack of coverage, and agency-focused rather than child-centered care. LA-YES is in partnership with the Department of Health and Hospitals, the Office of Mental Health, the Office of Juvenile Justice, a community-based consortium for youth with serious emotional and behavior disorders and their families, public and non-profit child-serving agencies, public and charter schools, advocates, and public officials. The consortium came together for the well being of children to address issues of capacity, the desire for quality services and the demand for total systems reform.

The Louisiana State Law Institute's Subcommittee on the Children's Code continues to meet and develop reforms. HCR 0005 was established in the 2006 regular legislative session to continue the study of issues relating to juvenile competency by creating a task force and to extend the period of time for the study of such issues. The resolution requests the House Committee on Administration of Criminal Justice and the Senate Committee on Judiciary B to meet and function as a joint committee to study and recommend policy directives for the state of Louisiana regarding these and other issues related to juvenile competency. Issues still being researched are the process of competency determination, restoration, and mental health intervention; recommendations for a plan of statewide implementation; and determination of the cost of implementation. Recommendations from the Assistant Secretary of the Office of Mental Health are included in the dialogue of the committee.

HB 503 was established in the 2006 regular session and was designed to be a broad sweeping legislation enacted as a result of the work of the above-mentioned task force and the Louisiana State Law Institute Subcommittee on the Children's Code. The Office of Mental Health with the assistance of the Office of Youth Development and other individuals and agencies as needed has developed and is currently modifying its own training curriculum for juvenile competency restoration providers who are licensed by their respective state boards and are employed with DHH. The curriculum is modeled after best practices utilized by leading states in this field of study. The initial training for private providers in the community began with a group of approximately 40 providers. In order to remain certified, a restoration provider must complete additional training every two years. In 2009, approximately 20 of the original certified providers completed training for recertification. Ongoing training for new providers is in the planning stages. OMH has established and will maintain a website of DHH qualified providers. OMH's full-time Juvenile Competency Restoration Provider continues to provide services primarily in Jefferson and Orleans Parishes, but travels around the state as needed.

In the 2008 regular session, ACT No. 222 was passed to revise sections of the Louisiana Children's Code pertaining to juvenile competency. The Code was revised to state that one member of the competency commission must be either a physician or a psychologist licensed to practice in Louisiana. The revision also made more specific the requirement for competency determination to "a preponderance of the evidence." A competency commission must be appointed to examine the child within 7 days of the court ordering a mental examination. In addition, children in the custody of DHH who are believed to regain competency must have a contradictory hearing within 10 rather than 30 days.

Legislation affecting child and youth involved the issue of court ordered restraint of youth who are considered dangerous or a flight risk during transportation from a secure facility to court for mandated hearings. ACT 230 allows the court to authorize the Department of Health and Hospitals to use appropriate restraints on a child who presents as a danger of flight during transport. Use of

restraints pursuant to the provisions of this Section must comply with the policy of the Department of Health and Hospitals on seclusion and restraints.

ACT 253 provides for the conversion of Jetson Center for Youth to a regional treatment facility. Jetson was previously cited for a high rate of violence, abuse, and escapes. The intent of this legislation was to reduce the size of the facility and transform it into smaller home-like residences with better trained staff that would create a supportive recovery oriented atmosphere for incarcerated. There was discussion about closing the facility, but current legislation allows Jetson to remain open, with the mandate that the design shall limit the dormitory capacity to twelve youths, and implement a therapeutic setting. The regional facility will be limited to housing not more than ninety-nine youths. The Act further mandated that a reorganization of the strategy for treatment include: Use of standardized and validated assessment of youth risk need factors; Use of treatment interventions that target known predictors of crime and recidivism to prepare for youth offenders for success in the community; Use of evidence-based programs; Staff development; Family involvement; Continuous quality improvement and evaluation of programs; Staff-to-youth ratio in secure facilities with plans to achieve a staffing structure consistent with positive behavior treatment models; and Statistics of percentage of youth involved in fights in secure facilities with improvement plans.

Criterion 4: Targeted Services to Rural and Homeless and Older Adult Populations

Louisiana is a largely rural State, with 88% (56) of the State's total (64) parishes being classified as rural according to the US Bureau of Census definitions. Consumer surveys consistently rate transportation as a major impediment to the receipt of mental health services. Attempts to ameliorate this problem include the provision of transportation through contracts with transportation providers and the establishment of satellite clinics in underserved and rural areas. Prior to the hurricanes, there was an OMH mental health clinic or Satellite/ outreach service in 45 of the 56 rural parishes. Satellites often operate with non-traditional hours.

Although OMH has placed many new programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in the rural areas of the State has long been problematic, not only for OMH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but also limits access to employment and educational opportunities. The resulting increased social isolation of many OMH consumers with SMI who live in these areas is a primary problem and focus of attention for OMH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas have seen increases in both.

In an attempt to alleviate access problems, OMH has available teleconferencing systems at 66 sites, including Mental Health clinics, ECSS sites, Mental Health Hospitals, LA Spirit, and OMH Central Office. Some sites have multiple cameras. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their cameras for both Telemedicine and Teleconferencing.

Estimates of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 9,634 persons, or 30% of the total 32,112 homeless served by the shelters who reported for the 2008 survey. Aside from the dire need to create a new stock of affordable housing to replace that lost in the hurricanes, there is a considerable need for rental subsidies to address the escalating housing costs in a market (unlike much of the United States)

where demand is high and supply is low. In addition to the rental subsidies, there is also a great need for community-based support services to assist people with mental illness in attaining and retaining their housing. At a minimum, an increase in available outreach programs that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed. Funding through the Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. The availability of a statewide system of Strengths Based Case Management would be a significant improvement in the quality of community based supports available to persons with mental illness. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers, increased access to existing housing stock, and expansion of resources for housing development and support services continues. OMH and mental health advocates have been extremely active in efforts to insure that people with disabilities are included in housing and rebuilding efforts. These efforts have resulted in some success; for instance, the commitment to the development of 3,000 units of permanent supportive housing. Permanent supportive housing is a best practice and offers the greatest degree of consumer choice. These qualities are consistent with Goals 2 & 5 of the *New Freedom Commission Report*.

Rural services, transportation, and services for the homeless populations will continue to be priorities for the State. Local transportation issues have become more pronounced as a result of budget cuts, with decreases in the availability of public transportation and rising costs. The goal of having available, accessible rural mental health services and services for homeless consumers in each region and Local Governing Entity (LGE) remains a challenge, and has become more so, given strained resources, staffing shortages, and the economy.

As part of the *Louisiana Road Home Recovery Plan*, the Louisiana Recovery Authority (LRA) included in its plan the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina and Rita. This is to be accomplished through a system of housing development funding incentives that encourage the creation of mixed income housing developments. Also included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities. It is a model that provides for housing that is fully integrated into the community through allocation of a percentage of housing units for persons in special population categories within each housing development built, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI, families of children with emotional/behavioral disorders, and frail elderly persons are included within the identified special needs population targeted for the 3,000 supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability.

Services to older persons with SMI are a statewide area of need. The Department of Health and Hospitals recognized this need in recent years, and developed the Office of Aging and Adult Services (OAAS). Although this new Office is not limited to serving the mentally ill population, collaboration is anticipated between OMH and OAAS. As the population ages, the number of persons with Dementia of the Alzheimer's Type and other dementias are predicted to increase. The Office of Mental Health has no specific treatment programs for these conditions, although the office is a participant in an interagency Alzheimer's disease task force mandated by the legislature to study and make recommendations for the future.

The Louisiana Spirit Crisis Counseling Program (CCP) has included the provision of essential crisis counseling services to those with special needs including older adults who were impacted by Hurricane Gustav. These services are funded by a grant from the FEMA Crisis Counseling program administered by SAMHSA through the Center for Mental Health Services (CMHS). Under different grants, Louisiana Spirit staff has been reaching out to priority populations since September of 2005, immediately after the hurricanes hit the Gulf Coast. Recently, Louisiana Spirit Outreach Workers and Crisis Counselors have canvassed most of the State offering crisis counseling services to those impacted by Hurricane Gustav. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. Louisiana Spirit counselors have worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals have lived since being evacuated after the storms.

Specific Regions and LGEs report having some programming that targets older citizens, however, the need is great, and the services are not consistently available across the state.

Criterion 5: Management Systems

Local Governing Entities (LGEs) have expanded to cover four of the State's ten regions, and as of July 1, 2009, a fifth Region has changed to an LGE. Other regions are continuing to evaluate their readiness to become LGEs, since the development of an all-LGE system has been legislatively mandated. This transformation will necessarily lead to changes in the current OMH state-operated Region system. The challenges of such a system-wide change are many, including allocation of funding in an equitable and cost-effective way for consumers of mental health services, and the provision of a consistent quality standard for services.

At the request of the Planning Council, and with the leadership of the Assistant Secretary, a study of the allocation of Block Grant funds was made in the spring of 2009. An ad hoc committee of the Planning Council was formed to study and make recommendations concerning the allocation of Block Grant funds. It had been recognized that within the state, Block Grant funding patterns to the Regions/ LGEs had little or no relevance to the services or needs of each Region/ LGE. Rather, the distribution of funding had its basis in a history that may have had a rationale at the time, but no longer made sense. The committee held two meetings and studied various options. The option that was ultimately recommended consists of dividing the amount of funding given to the Regions/ LGEs into ten equal amounts (i.e., $1/10^{th}$ of the funding would go to each Region/ LGE). The Assistant Secretary approved the proposal, and these changes will be phased in over a three year period, beginning with the 2011 Block Grant.

Prior to the hurricanes, OMH had initiated efforts to obtain JCAHO accreditation for all of the OMH-operated community mental health clinics and to LGEs wishing to accredit their community mental health clinics. Although still a goal, of necessity, the venture was scaled back due to other pressing needs. Instead,

In an effort to increase credibility, focus activity on performance, develop a common language, ensure consistency and uniformity, and provide a foundation and vehicle for system enhancement, the *Cornerstone Model* was initiated within OMH in 2006. The model focuses on four areas that will standardize business practice and service delivery within the state. It is also intended to introduce

best practices in clinical care, human resource management, and business operations. Progress is being made and is discussed in detail within this document.

The Office of Mental Health Workforce Development Bureau has provided the OMH staff with a variety of best practice/ continuing education opportunities. The goal of these activities is to ultimately enhance the quality of services provided to clients. The Workforce Development Bureau has continued to serve in the role of strengthening community-based services by enhancing capacity, and utilization of best practices. Consistent with objectives stated in Goal 5 of *The President's New Freedom Commission*, the Bureau has accomplished several trainings each year. The Bureau also works to provide OMH staff with continued education. There is a mechanism in place for Psychologists, Social Workers, and Licensed Professional Counselors to earn Continuing Education Units for appropriate workshops and learning experiences in order to maintain licensure by their respective licensing boards.

Launched in January 2008, *Essential Learning*, a Learning Management System, provided in conjunction with the Office for Addictive Disorders and the Office for Citizens with Developmental Disabilities and with the support of the Department of Health and Hospitals training staff has maintained a high priority in training provision. The system provides online training, provision of continuing education credits and a learning management system to track training in the three offices. *Essential Learning*, while originally funded through the Co-Occurring State Incentive Grant (COSIG), has been maintained by the three offices for ongoing use. It has been utilized by staff wishing to obtain the Certified Co-Occurring Disorder Professional credential offered by Louisiana Association of Substance Abuse Counselors and Trainers (LASACT). Another major project utilizing *Essential Learning* was the online registration and evaluation for the Level of Care Utilization System (LOCUS) training provided in 2009.

The 2008 statewide OMH leadership conference took place on October 1-3, 2008 with the theme of workforce development. Conference institute tracks and workshop tracks successfully provided staff members with many opportunities to learn and enhance skills, improving the quality of the OMH workforce. Workshop topics included Rational Emotive Behavior Therapy, Brief Strategic Family Therapy, Functional Family Therapy, Treatment of Insomnia and Sleep Disorders, Socio-Ecological Systems Treatment, Trauma Informed Care, and Multi-Systemic Therapy.

The development of credentialing and competency reviews for physicians is ongoing. These same processes for other licensed professionals working in community services are now in development and/ or in progress. These services are being provided through professional contracts within the Office of Mental Health.

Two major skills development trainings have been conducted during the spring of 2009. Dialectical Behavior Therapy training took place in two sessions, May 4-6, 2009 and June 22-26, 2009. In addition, five Cognitive Behavior Therapy training workshops took place across the state with participants from OMH Regions and Hospitals. The Office of Mental Health remains committed to the continuing development and expansion of an effective, efficient workforce. Emphasis is on the implementation of evidence based practices within OMH.

The Office of Mental Health continues to redirect state hospital resources toward specialized treatment programs promoting further integration with community-based services, and providing community-based options for those persons who have been in long-term state psychiatric hospital

care. OMH continues to evaluate the current utilization of personnel and to redirect inpatient staff positions to community-based services whenever possible. One example of this is the successful redirection of inpatient nursing and social work staff into Assertive Community Treatment teams that began in FY 2003, and has continued.

A continuing critical gap is in the level of crisis response services for adults, children, youth and their families. It has long been recognized that this basic service component needs to be further augmented to meet the demand. The hurricanes of 2005 drew further attention to this need, and measures have been taken to improve the available services and emergency response. Each community region has maintained the basic elements of a twenty-four hour crisis response system in the form of hotlines, crisis evaluation, and regional acute inpatient units. However, resources are not at a sufficient level to meet the need, and mobile crisis response services are very limited or unavailable. The capacity to respond to bio-terrorism and/or disasters of any type is inadequate, but has improved substantially with the initiation of several training programs that have been offered to OMH employees. In addition, the State has administered the Louisiana Spirit Crisis Counseling Program (CCP) under the Hurricane Katrina/ Rita and most recently Hurricane Gustav, CCP grants.

As a result of these grants, Louisiana Spirit has provided short term crisis counseling services to those impacted by the hurricanes; the program has also assisted survivors in connecting with local resources when this was needed. Again called to action as Hurricane Gustav approached the coast in 2008, Louisiana Spirit staff provided crisis counseling and support at staging sites and in the transportation process as citizens were evacuated from New Orleans and other coastal areas.

OMH has partnered with the Office of Public Health to provide regular trainings to OMH staff statewide on crisis response. The training curriculum is culturally competent and addresses the mental health needs of responders as well as special populations such as the elderly, medically fragile, and children and families. OMH also recently provided two trainings in Psychological First Aid to OMH staff members. National Incident Management System (NIMS) training has been made a requirement of employment by OMH.

OMH maintains a registry of appropriately credentialed behavioral health professionals who are able to provide assistance in disaster mental health, stress management, and multiphase response to disaster incidents. This registry includes both OMH employees and health professionals from the private sector.

Fortunately, no hurricanes struck Louisiana during the 2006 or 2007 season, allowing time for further enhancement of behavioral health disaster response plans for each hospital and outpatient facility in OMH, as well as in the Office for Addictive Disorders (OAD) facilities. When Hurricane Gustav hit Louisiana on Labor Day of 2008, followed by Hurricane Ike only days later, much had been learned and new processes were in place. However, as with the nature of crises, each hurricane is different and creates different challenges and learning opportunities.

The OMH service delivery system includes a comprehensive array of services organized to meet the needs of adults with serious mental illness, and children/youth with emotional/behavioral disorder and their families in each region of the state. However, each of the components of the comprehensive service system exists at a level that is far below that required to satisfactorily meet the demand in each region. This is due mainly to fiscal and workforce constraints, and is not due to a lack of

awareness about needs, nor due to lacking the will to establish a maximally responsive and comprehensive system of care.

Fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply. For example, insufficient numbers of direct service providers to address basic treatment and support needs of the community service population continues to be problematic. A common complaint expressed in surveys of consumers is not being able to see their therapist or doctor often enough, and having to participate in group treatment rather than more individualized treatment. The lack of treatment resources inhibits the ability of the State to provide as much in the way of outreach programming as would be ideal. A lack of healthcare providers continues to be a pressing concern statewide, and is particularly critical in coastal areas; even with innovative recruitment programs such as sign-on bonuses, loan forgiveness, and relocation expenses.

Additional steps are being taken to increase access to qualified prescribers in the community mental health system. OMH has developed a policy that now will permit local CMHCs to contract or employ Medical Psychologists (MPs) and Nurse Practitioners (NPs) who can prescribe psychotropic medications. This policy is designed to ease the burden on the limited number of psychiatrists who are available in the state, particularly in the more rural areas that have found it difficult if not impossible to recruit and retain these medical specialists. There are several Regions in the state that have begun to successfully utilize non-physician prescribers.

The per-capita expenditure for services remains below the national average despite exceptional efforts on the part of stakeholders to provide more sufficient funding levels for mental health programs. Efforts to ease the fiscal needs of the system require a continuously adapting and flexible workforce. Although certainly not yet widespread, and in itself an area of need, the implementation of evidence-based practice provides a framework for the future and a direction for the training of healthcare providers.

Early intervention and prevention programs are essential in meeting the mental health and substance abuse needs of the children/youth and their families. Generally speaking, youth in the custody of the child welfare and juvenile justice system receive mental health and substance abuse treatment in restrictive settings. The private sector provides mainly outpatient services and is not generally a rich resource for the population that OMH serves. Although there have been significant strides made in the implementation of a continuum of care for children and youth that is based on best-practices and evidence-based programs, there is no argument that the population of child/youth with EBD is substantially underserved; and the OMH capacity to serve this population is grossly under-funded and inadequate to meet the continually growing mental health and substance abuse needs.

In summary, many of the activities that are administered or supported by OMH were disrupted as a result of Hurricanes Katrina and Rita in 2005 and again by Hurricanes Gustav and Ike in 2008. The opportunity to re-build a *better* mental health system is recognized by all, and is the ultimate goal of the Office of Mental Health.

SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM'S STRENGTHS, NEEDS, & PRIORITIES
RECENT SIGNIFICANT ACHIEVEMENTS
LOUISIANA FY 2010 - ADULT & CHILD/ YOUTH PLAN

The Office of Mental Health continues to address the day-to-day challenges that are faced by a state that has been battered with four major hurricanes in three years. The efforts listed below support the continuing goal of reforming the mental health system. It should be noted that these OMH objectives support achievement of both *Louisiana's Plan for Access to Mental Health Care* and the *President's New Freedom Commission Goals*. While there are also many mental health system reform activities and initiatives underway statewide, the challenge to the state is to bring these efforts together into a comprehensive mental health plan for Louisiana that provides quality services that are effective and efficient within the resources available to the state. There are many examples of achievements that are discussed in detail in other sections of the Block Grant Plan, but a few are highlighted here.

Re-Organization of Metropolitan Human Services District

The transformation team, put in place by DHH to assist in the re-organization of Metropolitan Human Services District, has evolved from its original capacity to one that is more informal in nature. OMH continues to be a collaborative partner in transforming the access and delivery system of Metropolitan Human Services District as it rebuilds its system of care after the devastation caused by Hurricane Katrina. Specifically, assistance is being provided through the implementation of evidence based programs for those adults most difficult to serve, as well as the creation of a system of care for children and their families.

For adults, OMH is actively funding and monitoring the implementation of an Assertive Community Treatment (ACT) program and a Forensic Assertive Community Treatment (FACT) program. ACT is a treatment approach that is designed to provide intensive, community-based psychiatric treatment to persons with serious and persistent mental illness. It is a multi-disciplinary team approach with a 1:10 staff to client ratio, with the ability of services being provided 24 hours a day, 7 days a week as needed. ACT is an evidence-based service, that has been proven effective for those clients with severe and persistent mental illness for whom traditional services has not been effective. FACT is the same model, but with the integration of judicial components for the forensically involved population. Both teams funded by OMH accept referrals from the MHSD catchment area and are capable of serving up to 100 individuals in each team. Just one year after implementation, both teams are at capacity after a period of rapid start up in order to meet the mental health needs of the city.

In conjunction to the ACT and FACT programs through MHSD, a Permanent Supportive Housing program was implemented through Volunteers of America-Greater New Orleans. This program accepts referrals from the MHSD and JPHSA ACT and FACT programs for housing placement and rental assistance. To date, approximately 206 individuals have been placed in safe, secure housing.

Specialized Assistance Targeted to New Orleans

Special legislation was passed in the 2008 Regular session of the Louisiana Legislature that established funding for several initiatives to help citizens from the New Orleans area who were affected by the 2005 hurricanes. Within this legislation are several programs and initiatives. These include:

- 24/7 telephone crisis screening and referral system
- Additional support for the already ongoing CIT training
- Additional mental health staff for the New Orleans Parish prison (includes social work, substance abuse, and psychiatry staff) and extends medication availability
- Staff positions (30) to serve storm-affected individuals who do not meet the typical criteria for treatment at the mental health clinics
- A crisis receiving center as a pilot project

The Child and Adolescent Response Team (CART), a program that provides crisis services for children and youth twenty-four hours a day, seven days a week, was reestablished in Orleans, St. Bernard, and Plaquemines Parishes.

The Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams in New Orleans, as mentioned in the previous section, and the ACT team in Jefferson Parish were developed in response to the ongoing mental health crisis in New Orleans. The 2008 tragic death of a New Orleans police officer, Nicola Cotton, emphasized the need for these teams. The teams are currently operating at full capacity just one year after accepting their first clients. This rapid start up of services has resulted in the intensive service provision of community based mental health services for up to 300 individuals. Housing has also been a need that has been targeted through the development of a housing program (also mentioned in the previous section). Through this subsidy program in New Orleans and Jefferson Parish, housing has been provided to 206 individuals with mental illness, some of whom have co-occurring disorders.

Road Home Housing Program & Permanent Supportive Housing Program

The housing plan for people with disabilities, called the Permanent Supportive Housing Program (PSH), is in effect and gaining momentum. This program developed by the Louisiana Recovery Authority following the hurricanes will provide access to affordable housing in the Gulf Coast areas where housing was destroyed. While not a direct initiative of OMH, input from the office and consumer groups was received and acted upon. The program is designed for 3,000 units of permanent supportive housing to be developed for households with special needs such as: the frail elderly; those transitioning out of foster care; and those with disabilities, including mental illness, as well as households with disabled children in the Gulf Opportunity Zone (GO Zone). Due to the post-disaster increased cost of housing, the state requested and received 3,000 rental subsidies for the program last summer. These subsidies are in the process of being implemented and the pace of placement is picking up. The program is currently serving 636 households. As anticipated, a large number of them have a mental illness. While the program is still in the process of establishing its data base structure, it is estimated that about 60% of the households currently served have a member with a mental illness. Due to the housing development activities for this program it is anticipated that it will eventually serve approximately 3,300 people over the original 3,000.

Louisiana Spirit Hurricane Recovery

Louisiana Spirit is a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Louisiana Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana, which focuses on addressing post hurricane disaster mental health needs and other long term disaster recovery initiatives, in coordination with other state and local resources. Crisis Counseling Programs are an integral feature of every disaster recovery effort and Louisiana has used the CCP model following major disasters in the state since Hurricane Andrew in 1992.

The expansion of crisis services and education for trauma survivors has continued with a grant from the FEMA Crisis Counseling program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant allowed the development of a program that offers essential mental health services in the aftermath of the 2005 hurricanes, in an attempt to prevent the potential onset of more serious, long-term psychological problems and/or substance abuse. Federal funding for the Louisiana Spirit program from FEMA is ended December 31, 2008, making it one of the longest post-disaster FEMA funded crisis counseling programs in history. A Crisis Counseling grant was awarded after Hurricane Gustav hit Louisiana on September 1, 2008, during the same time that the Katrina and Rita grants were phasing out. The grant was awarded in late September of 2008. It is significant to note that during the last two years, Louisiana Spirit has won a total on 15 local, national and international awards for its various advertising campaigns and billboard advertisements.

Louisiana Integrated Treatment Services (LITS) & Co-Occurring State Incentive Grant (COSIG)

The creation of the Office of Behavioral Health is expected to further improve the identification and treatment of persons with co-occurring disorders. The Louisiana Integrated Treatment Services (LITS) Model is a DHH initiative to integrate treatment services for individuals with co-occurring disorders of mental illness and substance abuse. Statewide implementation involving both the Office of Mental Health and the Office for Addictive Disorders has been supported by a $3.4 million federal SAMHSA Co-Occurring State Incentive Grant (COSIG). Part of making operationalizing COSIG involved the use of two co-occurring disorder fidelity assessment tools: the Dual Diagnosis Capability in Addiction Treatment (DDCAT), and the Dual Diagnosis in Mental Health Treatment (DDCMHT). Both are used as measures in the Louisiana implementation of the SAMSHA funded Co-occurring Disorders State Infrastructure Grant (COSIG). OMH and OAD staff are considered experts in the use of these instruments and provided trainings to the South Carolina COSIG team during the last year.

Cornerstone Model Development

In November, 2006 the Office of Mental Health identified 4 primary components essential to the enhancement and maintenance of Louisiana's public mental health clinic system. These components taken together have been identified as the Cornerstone Model, and are designed to improve performance and accountability in the following fundamental aspects of a system of care.
The four areas of focus are:

1) Recovery and Resiliency;
2) Utilization Management;
3) Staff Competencies and Credentialing; and
4) Performance Improvement.

Through the influence of the Cornerstone Model, OMH has trained Peer Support Specialists who are successfully finding employment within outpatient clinics. Standardized target population definitions, service definitions, client profiles, intensity of need criteria, priority determination, authorization criteria, and service packages have been developed as part of the Utilization Management (UM) Cornerstone. Productivity standards for staff have been defined according to UM standards. A Directive from the OMH Assistant Secretary mandates the use of the Level of Care Utilization System (LOCUS) and spells out the time frames for its use. In addition to the traditional credentialing model from the hospitals, a credentialing plan has been completed for the clinic medical staff, and a credentialing plan to include a competency assessment program for other licensed treatment staff is in progress. Concentrated work on the Cornerstone initiative has continued, and is presented in detail in this document.

Early Childhood Supports and Services

Early Childhood Supports and Services (ECSS), implemented in the fall of 2002 and currently operating in 13 parishes throughout the state, identifies and mitigates the risks for young children, ages birth through five, who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, prenatal substance abuse, poverty, and developmental disabilities. The program has two main components to serve families: Infant Mental Health (IMH) and Temporary Assistance to Needy Families (TANF). Both services are provided in accordance with family needs. IMH assists with the development of the child and the attachment between parent and child. TANF services assist families during emergency times of crisis. All clinicians are advanced trained IMH Specialists. Clinicians within ECSS provide an excellent repertoire of behavioral management, and therapeutic intervention for both parents and children. Staff members are currently being trained in Parent Child Interaction Therapy (PCIT) Therapy. Each of the nine sites collaborate with local community representatives and advocates (private and public) that serve as network partners to develop a service plan for families in order to address identified needs. ECSS works closely with universities, elementary schools and other community partners, and has formulated a cooperative agreement with Head Start. ECSS has surpassed all targets set in FY 2008-2009.

Creation of the Office of Behavioral Health

The Office of Mental Health and the Office for Addictive Disorders will merge the administration and planning functions of each office into one. This move was made in order to allow for best practices in the treatment of individuals with mental illness, addictive disorders, and co-occurring disorders, while maximizing available funding. An implementation advisory committee is in the process of convening to make recommendations concerning the implementation of this legislative mandate, and will make a report to the Secretary of DHH no later than January 31, 2010. The advisory committee consists of 12 people representing consumers, advocates and professionals; with equal representation from the mental health and addictions communities.

Alternatives to Seclusion and Restraint

In 2004, the Office of Mental Health was one of a limited number of states to receive a three-year federal grant for the purpose of developing alternatives to the use of seclusion and restraint in their child and adolescent inpatient psychiatric facilities. The state was awarded a "no-cost" extension for the fourth year as a result of setbacks experienced secondary to Hurricane Katrina in 2005. The consensus among all those involved over the past four years is that the grant was a success. There was significant progress made within each of the facilities and among the staff with regard to policy and procedure, training, and cultural change. The facility-wide data indicated an overall reduction in both seclusion and restraint in all categories - percentage / patients, rate of events, and hours of use; the most notable reduction was in the use of restraint. Although the federal grant officially ended in early 2009, the facilities have committed to continue pursuing alternatives to seclusion and restraint. As of August 2009, at least two other programs/facilities not directly involved in the original grant have developed "Serenity Rooms" and received subsequent trainings.

Louisiana Youth Enhanced Services for Mental Health (LaYES)

In 2003, the OMH formed a collaborative of interested stakeholders and obtained funding from SAMHSA for a System of Care project for children with serious emotional disturbances and their families in the amount of $9.6 million for six years. The LaYES Consortium was formed to develop a comprehensive and coordinated community-based system of care for children with serious emotional and behavioral disorders, targeting youth who are at risk of placement or are placed in the Juvenile Justice System and /or the Child Welfare System. At the end of the sixth year of the grant, the project has delivered services to roughly 585 children and families in a five-parish area in and around New Orleans and has substantially implemented expansion of services to the remaining two parishes in its target area (St. Tammany and St. Bernard Parishes). The project has had numerous accomplishments, including the establishment of the LA-YES Training Institute, which provides training and continuing education units to providers, community stakeholders, and family members. Approximately 100 participants received training through the Training Institute in FY 08-09. The project has also solidified working relationships with several family-based grassroots organizations including the Federation of Families for Children's Mental Health, Families Helping Families, the Louisiana Children's Museum, the Children's Defense Fund, and others. Electronic data systems have been developed to support the intake process, the service authorization process, the credentialing and contracting process, and the evaluation process. LaYES established a community forum for children's mental health and conducts monthly meetings to develop, plan and implement strategies to collectively advance and sustain the children's mental health system through collaborative and creative programming and funding efforts. LA-Y.E.S. has continued to operate a School-Based initiative that targets students in charter schools in the greater New Orleans area.

Information Technology and Decision Support

The Division of Planning, Data Management and Compliance is dedicated to the ongoing development and use of information technology in support of quality improvement, performance accountability, and data-based decision-making statewide, and for each OMH Region, LGE, and state hospital. With progressive implementation of the Office of Mental Health Integrated Information System (OMH-IIS), legacy systems are being phased out in favor of one, comprehensive, integrated web-based information system. Additional OMH-IIS modules have been developed, including Assessment; Admission/Discharge/Transfer, and Service Ticket/ Progress note. Plans and training are underway for the acquisition and implementation of a statewide Electronic Behavioral Health Record system. The Division has continued to enhance the OMH data Warehouse and decision support system (Decision Support On-line) for statewide client-level administrative data, and the consumer quality-of-care survey program (using standard MHSIP-based questionnaires). OMH recently focused efforts on implementing systems to support the Cornerstone Utilization Management Program, including the adult Level of Care Utilization System (LOCUS), electronic Centralized Appointment Scheduling, and client-level outcome monitoring. The CA-LOCUS for children and adolescents will extend the level of care determination to the C/Y population. Training for the web-based Service Process Quality Management (SPQM) System is occurring with the aid of monthly consultation. Data-based decision making and performance improvement has been aided with the deployment of an executive dashboard displaying productivity measures including average provider direct time, appointment cancellations, and missed appointment data.

Provision of Appropriate Medications

OMH now has a policy that allows non-physician professionals who have prescriptive authority to prescribe within OMH facilities. The inclusion of Medical Psychologists and Advance Practice Nurse Practitioners allows patients and consumers greater access to the care they need. Several mental health clinics have taken advantage of this added resource to the benefit of their consumers. The pharmacy continues to offer an unrestricted formulary of medications for mental illness, which includes all of the newer antipsychotics, antidepressants, and mood stabilizers. The ability to offer this variety is due to the emphasis on the use of Patient Assistance Programs (PAP) that have decreased costs for the OMH pharmacies while making maximum usage of free and reduced-cost medications. In recent years, the cost of 70% of outpatient medications has been underwritten by PAP. Staff members have also assisted all clients who are eligible with obtaining Medicare Part D or Medicaid benefits. OMH has recently restructured its psychotropic medication formulary in another attempt to reduce costs. The Pharmacy and Therapeutics Committee along with a special committee composed of Regional Medical Directors developed a step-wise algorithm for the use of medications from various classes.

Cultural and Linguistic Competence Planning Committee

A Cultural Competence Plan came out of the work done by Louisiana Spirit after the hurricanes. Using the Center for Mental Health Services' nine guiding principles for cultural competence in disaster mental health programs as their guide, as well as data and information gathered from focus groups, a Cultural Competence Plan was developed. Through workshops, staff members are being trained in cultural and linguistic competence. One of the primary learning objectives was to train staff that cultural and linguistic competence is a journey and a process; and the most ardent champion spends a lifetime acquiring skills that continue to make them more culturally competent. The trainings have begun to create change at a system level that facilitates change at an individual level as well as at an organizational level. The Cultural Competence Plan is being used to guide, monitor and evaluate cultural and linguistic competence, so that citizens can receive appropriate services.

Judicially involved children and youth who require mental health services are addressed
The Office of Mental Health recognizes that there is a large number of youth with EBD/SED directly involved in the juvenile judicial system. In fact, many of those youth are either being serviced by two or more state agencies or are in joint custody of two state agencies. In a few cases, youth are transferred to the adult judicial system secondary to the nature and severity of their offenses; however, procedures are in place in order to provide for sanity and competency hearings for those identified juveniles. Those juveniles are directly assisted with age-appropriate methods in the determination and restoration of their capacity to proceed to trial. The Department of Health and Hospitals has developed and continues to revise rules and regulations for certifying juvenile competency restoration providers, and has developed a training module patterned after national best practices. The state continues to closely study issues relating to juvenile competency. In addition, the state's Law Institute Subcommittee on the Children's Code continues to meet in order to study the same issues while developing additional legislation regarding training as well as the protection of children's rights.

Multi-Systemic Therapy
MST is an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk for detention/ incarceration and at risk for psychiatric or substance abuse hospitalization, has shown significant results in reducing out-of-home placement, externalizing problem behaviors, rates of recidivism and lowering costs of treatment. The program is operating in Orleans, Plaquemines and St. Bernard Parishes. The teams began accepting cases in December of 2008.

Louisiana Youth Suicide Prevention
The Louisiana Partnership for Youth Suicide Prevention *(LPYSP)* addresses suicide, one of the leading causes of death among Louisiana's youth and young adults. The LPYSP is comprised of a broad range of state, local, public and private partners that serves as the governing body. This governing body leads the implementation, oversight, monitoring, evaluation and reporting of program activities that reduce youth suicides and suicide attempts in Louisiana. The main aims of the LPYSP are: Strengthening public and private partnerships by establishing a statewide team of experts; cultivating community efforts by creating five community coalitions with area leadership; mobilizing existing statewide and local suicide prevention and referral resources; expanding gatekeeper trainings by providing four types of suicide prevention trainings such as ASIST, Suicide 101, Safe Talk and ASIST Training for Trainers; and increasing awareness of youth suicide prevention through statewide observances. Under LPYSP leadership, various services are provided locally and statewide and include:

- Evidence-based suicide prevention trainings statewide to gatekeepers
- Depression/suicide risk school screenings and the development of peer helper chapters at Louisiana schools and universities;
- Stigma reduction and suicide awareness events such as the Annual Yellow Ribbon Suicide Prevention and Awareness Campaign, Walk for Youth Suicide Prevention, Poster/Essay Contest, Youth Rally on steps of the State Capitol, and the Annual Suicide Prevention and Awareness Conference.
- Annual Children's Mental Health Week Observance which LPYSP spearheaded in 2008 and 2009 in collaboration with 11 other agency partners.
- LPYSP sponsored the 1st Annual Children's Mental Health Summit
- Suicide prevention media campaign consisting of busboards, billboards, newspaper ads, radio and TV PSA's and educational materials.

Office of Client, Youth & Family Affairs

This office continues to actively work towards the development and statewide implementation of peer support programs, Wellness Recovery Action Planning (WRAP) and other initiatives that seek to encourage consumer/family choice and empowerment throughout the system of care as Louisiana moves towards a recovery modality. As of 2009, the Office of Mental Health began the process of implementing Peer Support Services throughout the state of Louisiana, using the curriculum developed by Recovery Innovations. Currently, there are 71 trained and certified Peer Support Specialists, 35 of whom are now employed in a variety of capacities throughout the system of care. Examples of job duties include conducting Peer Support and WRAP groups, working with clients on an individual basis to develop goals and serving as an aid in the transition process when clients first enter the clinic. In addition to the Peer Support program, the Office of Mental Health has also actively been integrating WRAP within the system of care. Currently, there are 69 trained WRAP Facilitators many of whom are conducting groups across the state. Since the inception of the WRAP is it approximated that over 1000 individuals have been introduced to the concepts of WRAP in some capacity. For 2009-2010, it is the goal of the Office of Mental Health to continue to fully support and certify peers and to ultimately train peers as trainers so that the program can achieve long-term sustainability. In addition a recovery website will be created that will serve as an information resource for those seeking to become WRAP Facilitators or Peer Support Specialists along with other relevant information related to recovery and wellness.

Disaster Recovery and Preparedness

Hurricane response was once again tested on September 1, 2009 when Hurricane Gustav hit the coast of Louisiana, debilitating much of the capital city and seat of government, including the administrative offices of OMH. Shortly after Gustav hit, Hurricane Ike hit southwest Louisiana, creating yet another disaster declaration. Lessons learned from the hurricanes of 2005 were instrumental in minimizing the traumas associated with the previous hurricanes. State, regional, and hospital disaster recovery and emergency preparedness plans ensuring maximum interagency collaboration are continually being evaluated and refined; as it is clear that no two disasters are alike, each bringing unique challenges. The staff of OMH is committed to benefiting from the lessons learned. To this end, OMH continues developing disaster response and recovery plans that build on partnerships, both public and private.

Transition to Local Governing Entities (LGEs)

Legislation was passed during the 2006 legislative session calling for DHH to develop a plan to facilitate the remaining geographic regions to transition to local governing health care districts or authorities. As of July 1, 2009, a new LGE was formed, bringing the total to five. There are five Regions remaining who are in various stages of preparation to become LGEs. Local governing entities (LGEs) have the responsibility for providing services to persons with mental illness, substance use and abuse disorders, and developmental disabilities. The newly created Office of Behavioral Health will modify the organizational structure at the administrative level and align leadership to achieve strategic directions and support transition to Human Service Districts.

Louisiana's Plan for Access to Mental Health Care

Through a comprehensive health planning process that included input from communities across Louisiana, *A Report on the State of the Mental Health Delivery System in Louisiana* was delivered. This report acknowledgement that in order for meaningful progress to occur, reform must take a broad coordinated approach involving federal, state, and local governments, public/ private partnerships and citizens coming together. Out of this activity came a mandate to develop a comprehensive transition plan for the Louisiana's mental health system, with DHH as the lead agency. The charge of this group was to develop a comprehensive and effective plan for the transformation of Louisiana's mental health care system, including recommended administrative and legislative actions that may be reasonably achieved by 2010 with available resources.

The status of this plan is presented in Part C, Section II, and titled *Louisiana's Plan for Access to Mental Health Care.*

- The Office of Mental Health is committed to the implementation of this plan which significantly changes how mental health is viewed in Louisiana and how services essential to positive mental health and quality mental health treatment are delivered.

OFFICE OF MENTAL HEALTH

VISION

We envision a future in Louisiana where every individual has the opportunity to live a full, satisfying, and productive life in their community.

MISSION

OMH will advance a *Resiliency, Recovery* and Consumer focused system of person centered care utilizing best practices and evidence based practices that are effective and efficient as supported by data from measuring outcomes, quality and accountability.

OFFICE OF MENTAL HEALTH PRIORITIES

TEN PRIORITIES FOR A RESILIENCY/ RECOVERY SYSTEM OF CARE IN CONCERT WITH CONSUMER AND STAKEHOLDER RECOMMENDATIONS
1. Serving youth, adults, and families affected by serious mental health and co-occurring disorders (MH/AD/DD) with Best Practices and Evidence Based Practices
2. Improving access (entry) to care through an integrated health care system
3. Reducing stigma
4. Using Utilization Management to ensure people receive the right care
5. Increasing Cultural and Linguistic Competency
6. Competency in coordinating care for high end users (most seriously ill)
7. Ensuring the use of valid and reliable data in decision making
8. Provision of training, skills assessment, re-training, monitoring, and outcome/ quality measures.
9. Manualization of practices
10. Focusing on Prevention and Early Intervention

OFFICE OF MENTAL HEALTH ORGANIZATIONAL INITIATIVES - 2010

Through the "Cornerstone Initiative" OMH is building the structure for the delivery of person-centered care. The foundational elements are: 1) Recovery and Resiliency 2) Utilization Management 3) Workforce Development 4) Performance Improvement. Examples of current projects under the Cornerstone Initiative are:

- Improved access to care
- Monitoring outcomes
- Implementation of best practice treatments
- Managing change
- Data decision making strategies

OFFICE OF MENTAL HEALTH KEY GOALS FOR 2010

- Consolidation of OMH and OAD into the Office of Behavioral Health
- Expanding access to services for children and youth
- Increasing the number of evidence- based practices with empirically derived fidelity measures
- Enhance workforce clinical competencies
- Increasing accountability for the services and care provided to the people of Louisiana